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**Clinical Lectures.**

**PLEURISY WITH EFFUSION.**

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*Gentlemen:*—The patient before you is a painter; age 40; single; born in United States. The resident physician, Dr. Hunter, has obtained the following notes of his case and previous history: The mother died of throat consumption at the age of 70; father is still living and well. Three sisters have died of phthisis, at 26, 36 and 35 years respectively; one brother died of phthisis at 48 years of age. There is no other hereditary disease in the family. The patient has always enjoyed good health until the onset of present illness, which occurred about January 1st, 1892. The first symptoms were those of la grippe, viz: cough, aching of the bones, slight febrile movement. After 10 days he developed such symptoms as stitch-like pain in the left axillary region, dyspnoea, with catching respiration and at the same time there was a slight increase of temperature. The physical signs of pleural effusion were noted by the physician in attendance at that time. The cough was hard and harassing, with very slight expectoration. He was confined to bed for 6 weeks from the date of onset. Since he left his bed, 4 weeks ago, the cough has gradually diminished, while he has gained 4 pounds in weight. He still has slight cough, slight pain on deep respiration and moderate dyspnoea on exertion. He has never had night sweats.

One week ago, we noted the following physical signs: on inspection, the lower half of the left chest was observed to be somewhat retracted posteriorly. The expansile movements were slightly increased on the right side and over the upper portion of the left. Over the lower half of the left side the movements were very slight indeed. No retraction was noted anteriorly, or in the left axillary region; only posteriorly.

On palpation, the vocal fremitus was found to be normal on the right side and over upper two-thirds of left side posteriorly. Anteriorly, vocal fremitus slightly exaggerated over upper portion of left side, whilst over lower lobe of same side laterally and posteriorly, almost totally absent.

Percussion resonance everywhere slightly exaggerated except over lower portion of left side, where there was dullness even to flatness. The vesicular murmur was also slightly exaggerated over whole of right side and upper portion of left. Over lower portion of left side posteriorly and laterally, very feeble respiratory murmur was heard and at the extreme base, none at all. A pleuritic friction and creaking sound was heard in mid-axillary region. Near the base posteriorly, we heard crepitating friction sounds.

But, gentlemen, the one physical sign which is of infinitely more value than all those before mentioned combined, is the change in the upper limit of dullness on change of position of the patient. Whenever this is noted, we may be certain that the pleural cavity contains fluid. So soon as this fact was made out in the case before you, we confirmed the diagnosis of liquid effusion by the use of the hypodermic needle, by means of which we withdrew a small amount of straw colored fluid. The patient was treated by the use,

internally, of the so-called iodides, as per the following recipe:

R *Potassi iodidi..... gr. v.  
Syr. foedi. iodidi..... m. x.  
Syr. sarsap. comp. q. s. ad..... 3l.  
M. Sig. 3i. q. d.*

He returns to-day feeling rather better than when he presented himself for treatment one week ago. On making a careful physical examination of the left chest, it was found this morning that the amount of effusion had, within the past week, diminished to a noticeable extent, as the result, probably, of the treatment instituted one week since.

I had informed the man, after examining him for the first time, that in case the liquid effusion did not subside in the course of one week, I would resort to aspiration. However, since there has been considerable subsidence of the upper boundary line of dullness, it would not be the part of wisdom to interfere in this mechanical manner. His general condition is apparently very good; he has not had, for several weeks, any marked rise of temperature, indeed, as often as the temperature has been taken during this period, it has been found to be under 100° F., whilst to-day it is only 99° F. The cough has almost entirely disappeared and the dyspncea is also less marked on exertion. In view of the fact that he has steadily improved since he came under our care, we will continue the double iodides for at least two weeks longer. His diet shall be generous; he shall take a moderate amount of exercise in the open air and shall avoid exposure to wet and cold, and shall take a moderate amount of alcoholic stimulants in the form of milk punches.

Gentlemen, the history of this case represents several features of considerable interest. You may recollect that he gives the history of a well marked hereditary predisposition to tuberculosis, his mother, three sisters and a brother having died of the latter disease. Whilst the etiology of sero-fibrinous pleurisy is not very well understood as yet, there is a large number of competent observers who contend that in the vast majority of instances, this disease is secondary in the course of tuberculosis. I myself am of the opinion that pleurisy is very rarely a primary affection, and that it is more frequently a secondary process in chronic tuberculosis than in any other disease, though I cannot go so far as many French writers, who contend

that all pleurisies are tubercular. It is not to be inferred that pleurisy is non-tubercular in nature when gross lesions cannot be demonstrated in the lungs, since it has frequently been found that a very small tubercular infiltration of the pulmonary tissue has been followed by active inflammation of the pleura, indeed, we have no means of eliminating phthisis as a causal factor in cases of pleurisy. This is also shown by the fact that sero-fibrinous and plastic pleurisy are often the first step in tuberculosis. Here it is quite probable that the tubercular process is the primary one, it having merely been overlooked. We must, at all events, concede the fact that tuberculosis predisposes markedly to inflammation of the pleura and that the case under consideration is no exception to this law. Among children, pleurisy, according to my own observation, is less frequently tuberculosis in nature than among adults, though it much more frequently follows pneumonia.

I have just learned, a few moments prior to bringing this patient before you, that he is addicted to the immoderate use of alcoholic stimulants, and has been for many years. I mention the fact in this connection, for the reason that I sincerely believe that chronic alcoholics are very prone to suffer from attacks of pleurisy. You will not find chronic alcoholism put down in most of your text books as a causative factor in this disease, but I am convinced that a little careful observation will lead you to a similar conclusion.

We found that this patient suffered from influenza for ten days prior to the development of the pleurisy. Pleurisy, it should be recollect, occurs quite commonly in the course of all acute infectious maladies, and this is especially true of influenza. Every medical practitioner who enjoys a large clientele, must have observed, during the epidemic through which we have just passed, many instances in which pleurisy developed either in the course of, or subsequently to, cases of influenza. Influenza is to be looked upon, however, rather as a predisposing, than as an exciting cause of the disease. There is nothing in this man's history that would throw light upon the question of the immediate or exciting cause of the disease. Pleurisy may very frequently be traced to exposure to wet and cold, as well as to injuries to the chest wall.

The diagnosis of sero-fibrinous pleurisy is not difficult when the amount of effusion is large. Considerable difficulty is, however, presented when the effusion is small in amount or confined to limited areas on account of adhesions. So far as the subjective symptoms are concerned, it should be especially noted that they do not stand in any sense in direct relation to the extent of the effusion. I have frequently seen cases in which the amount of effusion was large, whilst there was almost entire absence of such symptoms as pain, cough or dyspnea; the symptom, pain, is especially misleading. On the other hand, cases often present marked subjective symptoms, notwithstanding the entire absence of liquid exudation, to be very carefully noted, since they are occasionally of value when we come to discriminate between this disease and acute lobar pneumonia. Under these circumstances, the physical signs do not betray very clearly, under certain conditions, the true nature of the morbid process within the chest. As a rule, however, the physical signs are quite diagnostic of pleurisy with effusion. This is particularly true, as before stated, when the amount is copious. Here, the well known signs, viz., restricted expulsive movement on inspiration, bulging, the absence of vocal fremitus on palpation, the flatness on percussion, the absence of or greatly enfeebled vesicular murmur, together with diffused bronchial breathing over the upper portion of the effusion, usually suffice to make a positive diagnosis. In the patient before you, when first seen, the amount of effusion was small, and it is under these circumstances that errors are frequently committed, simply through lack of due precaution in carrying out the well recognized methods of exploration, rather than from lack of skill. Had I discontinued my examination, of this case before ascertaining whether the upper boundary line of dullness shifted with change in the position of the patient, I should have made an incorrect diagnosis, for, up to this moment, I was of opinion that we had to deal with a thickened and adherent pleura simply. Having found, however, that the upper line of dullness changed on changing the position of the patient, I was obliged to make the diagnosis of pleurisy with slight effusion. Too much stress cannot be laid upon the importance of applying this crucial test

in cases in which the effusion is slight. It may not always be possible to make it even though a certain amount of liquid be present, more particularly if that should be sacculated. Under these circumstances, before concluding that no effusion is present, I would advise you to resort to the use of the hypodermic needle, which, if employed under antiseptic precautions, can, in the first place, do no harm, and will very frequently discover for you the presence of effusion, a condition of things that would otherwise be frequently overlooked. It is owing to the fact that the recognition of effusions however slight is of the utmost importance when we come to treatment of this affection, that I have placed so much emphasis upon this point in diagnosis.

I cannot to-day take up the subject of the differential diagnosis of this disease. I should like to call your attention to a few practical suggestions in connection with the treatment of this common complaint. In approaching the question of the management of this disease, it is all important to bear in mind that the effusion is the result, primarily, of an inflammatory process and is not a mere transudation. That inflammatory process is, within certain limits, self limited, most probably. If this be true, then one of the aims of the physician should be to limit the extent of, as well as the intensity of, the inflammation, by this means also limiting the amount of effusion. With a view of combatting the inflammation, we employ external as well as internal means. Locally, the use of counter irritants, such as mustard plasters, iodine, etc., are of value. Internally, there is perhaps no other remedy that fulfills so many indications as quinine; it should be given in doses of four grains every four hours. I would strongly advise against the use of internal antipyretics in the treatment of this disease, more particularly such as antifebrin, antipyrin and phenacetin. We are not certain of our ground as to whether, in this complaint, there is a toxic agent circulating in the blood and exerting a poisonous effect upon the heart, its ganglia and the nerve centers, but we do know that the heart is very much embarrassed on account of the liquid effusion displacing it and compressing the great vessels near it, and we do know further, that the blood pressure in this disease is usually quite low, as shown by the

small amount of urine secreted daily; hence, to depress still further the center of circulation, is not only uncalled for, but positively injurious. My reason for saying that internal antipyretics are not called for in this disease, is that the temperature is rarely above 103° F., and can be sufficiently lowered in a safer manner by the use of cold sponging of the surface and the use, internally, of quinine. Neither would I recommend the use of any of the arterial sedatives, for the reason that they too, in every instance, depress the circulation whilst relaxing the blood vessel walls and lowering arterial tension,—the very things that are to be scrupulously avoided in this disease. Another leading indication in the treatment of pleurisy has for its object the removal of the effusion. This may, in a great many instances, be left to nature herself. It is questioned, by some authorities, whether we can, by the use internally, of medicinal agents, stimulate absorption of the effusion, and whilst time will not permit me to enter into a discussion of this mooted question, I desire to state it as my honest opinion, that much can be done in this direction. I would advise especially, that you make trial of the mixture already rehearsed in your hearing. This has been employed by myself in not less than thirty cases, with apparent success; at all events, in nearly every instance in which the double iodides have been used, thoracentesis has been unnecessary.

The fluid should be withdrawn by mechanical means at any time during the course of a case of pleurisy when dyspnoea becomes urgent; when there is a tendency to syncope; when lividity of the eyes, lips and finger tips become marked, no matter how high the temperature. But unless the indications during the febrile stage are urgent, unless demanded on account of threatened asphyxia or syncope, it had better not be done, for the reason that when performed during the active inflammatory stage of the affection, there is apt to be a rapid return of the effusion. It is often a difficult question to decide how soon to aspirate after the temperature has declined to the normal or to a point near the normal, especially when there has been no noticeable diminution in the amount of effusion present. Under these circumstances, the leading indication is to get rid of the fluid, and if you have persisted in your efforts to assist nature to absorb

this fluid by the exhibition of remedies recommended for this purpose, during the entire course of the febrile stage and for one week subsequently, then I would advise you not to delay the operation of thoracentesis any longer. At your first operation, remove but a small portion of the effusion, at the same time continuing the use, internally, of the double iodides previously recommended. If, however at the end of another two or three days, no tendency is shown on the part of the effusion to subside, then a second aspiration should be done. The necessity for the removal of a large amount of effusion at any one time rarely exists, and the dangers that attend such a procedure are several, among the most serious being albuminoid expectoration and syncope, which are oftentimes almost immediately fatal, whereas the removal of a small portion of the effusion (say from 8 to 12 ounces) can do no harm if carried out under antiseptic precautions, no matter how frequently repeated. Again, frequently have I seen a single operation at which a small amount of the effusion was removed, suffice. More frequently perhaps, a second aspiration was required.

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#### TREATMENT OF TORTICOLLIS BY THE HYPODERMATIC INJECTIONS OF ATROPINE.

Leszinsky (*Revue de Therapeutique Medico-Chirurgicale*, 1891) has published a case of muscular torticollis, which was successfully treated by hypodermatic injections of atropine. The patient was a painter, 37 years old, in whom the affection developed without appreciable cause, perhaps under the influence of lead intoxication. The contractions were exaggerated by the movements of mastication, by the closing of the jaw, and even awakened the patient from sleep. Near the right angle of the mouth there was a point of complete anaesthesia. After having used various internal remedies and electricity without effect, the author made injections of atropine, beginning with  $\frac{1}{10}$  of a grain and increasing gradually to  $\frac{1}{5}$ . The cure was complete after eight injections. The author mentions a case of convulsive tic in a woman of fifty years, in which similar injections produced decided amelioration.—*Univ. Med. Mag.*

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**Communications.****SURGICAL INTERFERENCE IN  
CEREBRAL DISEASES OF  
CHILDREN.**

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It is the object of this paper to consider the advance made in the pathology and surgical treatment of the cerebral diseases of childhood. It is not deemed necessary to recite the history of this progress, nor to enter largely into the discussion of the theories upon which much of the modern surgical interference is founded. There can be no question as to the advisability of interference by surgical means, when the known pathological conditions are such as to warrant the hope for improvement. But gross theoretical speculations, as to the pathology, such as have been advanced relative to microcephalus are not scientific and are not sufficient to permit of operative procedure. Starr has aptly said, that the solution of the problem of operative treatment in cerebral diseases of childhood must be based upon these conditions: *First*, the pathology of the cases, and *secondly*, upon the results of experience when such operations have been done. The pathology of affections peculiar to childhood, has not received the study it deserves by operators and others advocating surgical interference; especially does this apply to microcephalus, the relief of which, by linear craniotomy, is now being strenuously advocated by surgeons on both sides of the Atlantic. While Lannelongue has modified the original theory, that advocated by Virchow, viz., that microcephalus was due to premature synostosis, by saying that the condition is due to maldevelopment in the cranium, and is secondary, yet, he persists in doing the operation, hoping thereby to stimulate brain growth. Microcephalus is a true pathological condition having intra-uterine arrestments of development as a cause. Whether disease of the foetus, or nutritive changes from other causes, are primary in producing this result, we are unable to

say. There is deficiency of structure as well as malformation of the brain, and synostosis is not a factor in producing this narrowing of the brain in all its diameters.

Concomitant as it is in almost all cases, yet microcephalus may exist without it. Down, of London, reports cases of microcephalus where the sutures were not closed, even the medio-frontal suture which is ossified during the first year of life, was open. He says, "In my own observation of the crania of two hundred idiots, the arrest of development was not the result premature ossification of the sutures." He further says, in speaking of one particular case, "I am desirous of placing on record this extreme degree of microcephalus, without any synostosis, as a striking example, in which other than mere mechanical causes, must be looked for as productive of this and analogous cases."

Shuttleworth, after reporting a similar case, says, "I am inclined to think that the premature synostosis is as a rule the consequence rather than the cause of imperfect brain development, and that the arrest of growth is about the sixth month of gestation."

Fletcher Beach supports this view; so also does Ireland, who says in many microcephalic heads the fontanelles are open and the sutures not united.

To Wilmarth we are indebted for much of the advancement made in the pathology of idiocy; he in his extensive autopsies has found but one case where any brain compression existed, while in most cases the convolutions were full and rounded. In a private letter to me he says, "There is very little evidence that microcephalic brains result from compression from the skull, but on the contrary there seems to be in nearly all cases an extra amount of subarachnoid fluid, with no flattening of the convolutions, or other indications of intra-cranial pressure, as if the skull had grown slightly beyond the brain. If the conditions arose from cranial pressure, all portions of the brain should suffer alike, as the brain may be regarded as fluid, so far as transmission of pressure is concerned. I agree with you that the defective growth is more often due to nutritive faults, which we do not at present understand."

My own studies based on anatomy, embryology, pathology and clinical obser-

\*Read before the Section of Neurology and Medical Jurisprudence of American Medical Association, June 8th, 1892.

vation have convinced me that in microcephalus we have to deal with conditions not amenable to treatment by surgical means. Anatomically speaking we recognize that intellectual development depends, as Meynert says, on the uniform structure of all parts of the brain. In microcephalus, we find absence of critical structure, necessary to normal mental development, and that the degree of idiocy is not dependent so much upon the degree of microcephalus, as upon the amount of structural deficiency. The smallness of the skull is no criterion of intelligence in these defectives. The structural deficiency is shown in effacement and interruption of convolutions, the simple and defective arrangement of fissures, the absence of the central portions of the brain, and atrophy of the lobes, especially the frontal and occipital. Microscopical examination shows diminution in number and absence of ganglionic cells in certain layers and deficiency of nerve fibres.

Embryology teaches us that the brain is developed early, but that it is not until near the fourth month the most important portions are shown, then it is the frontal, occipital, parietal and temporal lobes can be distinguished and the primary fissures are pronounced. The secondary fissures appear between the fifth and sixth months; the occipital lobe should cover the cerebellum at the sixth month, according to Beaunis and Bouchard. In the seventh month nearly all of the main foldings of the hemisphere come into view, the frontal lobe elongates, the sylvian fissure narrows to a cleft. In view of these established facts we conclude from observation of the brains of microcephalics, which in so many cases show evidences of arrestment, before the evolutionary processes above stated are completed, that arrest of development occurs at, or near the sixth month of gestation. An embryological study of the process of ossification does not sustain the theory that synostosis is the cause of microcephalus.

Embryology, shows that the vault of the skull is formed in membrane and the base in cartilage, and pathology often makes the distinction more manifest (McClellan), which it does in microcephalus; the ossification in the base is well advanced at birth, and the vertex may or may not, be completely ossified, according to the precocity of the osseous system, "existing

without any correlation between the growth of the brain and skull." Wilmarth says, "I am convinced that in the majority of cases the skull does not grow simply because the brain does not." My own observation is that skull growth is dependent upon brain growth only to the extent of localized nutritive interference, which while it may affect both brain and skull, does not necessarily do so as evidenced in synostosis and also in open fontanelles in microcephalus. We conclude that synostosis is the result of arrested brain development, without interference with the process of ossification. The results of experience when the operation of linear craniotomy has been performed, do not sustain the claims made for it, by Lanelongue and his followers. Statistics of operations performed, which I have been able to gather, show such meagre results and such great mortality both in this country and Europe, that it seems to me folly to continue to advocate linear craniotomy. Those who have survived the operation have in some instances, improved but there is no evidence to show that such improvement would not have taken place by as persistent efforts in training before the operation as after. Time, that important element which should be taken into consideration in estimating the results of linear craniotomy, has been lost sight of in the haste to report the operation. The efforts put forth to elicit improvement, and the attention given the child by the parents and all interested in the case would even in the most profound case of feeble-mindedness, have some noticeable mental improvement as a result. Those who are familiar with the training of feeble-minded children, have found no encouragement in the operation and one after another have assured me they have little "sympathy with that kind of surgery."

Persistent physiological education such as is to be had in thoroughly equipped institutions can accomplish more without linear craniotomy as an adjuvant.

The treatment of epilepsy has received much attention during the past year, both by surgeons and neurologists, and while our knowledge of the pathology of this disease, is still very obscure, we have advanced appreciably, as to the value of surgical interference.

All who are familiar with epilepsy are aware of the persistency of the attacks in

spite of all treatment, and how comparatively few cases are cured, clinical reports to the contrary notwithstanding. In a paper read before the Illinois State Medical Society last year, on epilepsy, I said, "All we do generally in the treatment of this disease is to render less frequent and less severe attacks; the removal of peripheral irritation makes the case more hopeful, but statistics are not encouraging as to the complete recovery, probably due to the establishment of the epileptic habit, which is due to the adjacent brain centers having become irritable and unstable." These statements were severely criticized, my prognosis was said to be too gloomy, and the outlook for epilepsy too discouraging.

Another year's observation and study only confirms my belief more strongly, for epilepsy is, as yet, a Gordian knot for the neurologist and surgeon to untie. Gray, Sachs, Ferrier, Dana, Wilmarth, and other authorities have contributed to the literature of epilepsy clinical observations which sustain my humble opinion. Surgical interference is justifiable and should be advocated in all cases of traumatic or organic epilepsy, providing sclerosis is not too far advanced.

In focal epilepsy we cannot predict the results following excision of the localized seat of irritation, *first*, because conditions more severe than the epilepsy itself may follow removal of the cortical substance; and, *second*, we cannot give assurance of the cessation of the spasms. I have in mind a case to which the first statement applies; a boy, an epileptic; trephined, and portion of cortex removed, the epilepsy ceased, but the boy became an imbecile, and is now an inmate of an Institution for Feeble-Minded Children. My second statement is illustrated by another case, a boy; trephined, epilepsy still continues; fits are more severe, and this boy has since been admitted to a Feeble-Minded Institution. We must not overlook the fact, that injuries comparatively slight and which would do little if any damage to the brain of an adult, in a child produce disastrous effects, and diffuse sclerosis results. Wilmarth, in his autopsies, has repeatedly demonstrated this fact, and while associated with him I had this so impressed upon me, that I am loth to advise trephining in the epilepsies of childhood, unless taken very early in the history of the case,

and even then we cannot offer much hope, for as Wilmarth says of his cases, "My post-mortem studies have led me to believe that while considerable injury may be inflicted on the adult brain with no great impairment of the mind resulting, the contrary holds in the child and brain injury from accident or disease is sure to permanently impair mental growth." Osler, likewise pointed out to me during his study of the cerebral palsies of childhood, the very diffuse formation of blocks of sclerosis and the improbability of surgical relief.

In his book, he says, "There are several circumstances which militate against the probable success of operations of this kind. When sclerosis exists the area is usually too large for removal, and it is only in exceptional instances we could expect the epilepsy to be relieved. I do not think that in any of the cases which I have reviewed, the anatomical condition offered the slightest possibility of relief from interference."

What then is to be the future of surgical interference in the epilepsy of childhood? We must be guided by the nature of the case; often no doubt we can by operating arrest the progress of the disease, perhaps cure it. Further, as Sachs says, in the cerebral palsies of childhood, the paralysis which so often precedes the epilepsy will be the guide for operative procedure by localizing the irritation; the centres should be exposed and be treated in accordance with the special indications of the case. He is confident that if these cases of infantile cerebral palsies are more generally recognized, and if we succeed in checking the tendency to epilepsy in them, the total number of epileptics will be notably diminished.

Operative interference in cases of defective sensory perception, as presented by Starr, in a recent paper on "Cerebral Atrophies of Childhood," seems to me to open up a field for observation for the neurologist, one promising some benefit in preventing, or at least ameliorating the condition of that great class of defectives, the blind, and the deaf and dumb. We all know that many, many of these cases, especially of the deaf and dumb, owe their trouble to cerebral diseases—diseases which medical treatment has failed to relieve, and we cannot but hope that surgery may ultimately find a way to benefit this unfortu-

nate class. Deaf-mutism is little understood and less studied by the neurologist, in fact a thorough aetiological study of this prevalent condition from the standpoint of neuro-pathology has not been scientifically undertaken.

Through the kindness of Dr. Gillett, Supt. of the Illinois Institution for the Deaf and Dumb, the largest institution of its kind in the world, I have commenced the study of deaf-mutism and hope to report my progress at the next meeting of this Association.

In conclusion, I would say surgery has its field of usefulness in cerebral diseases of childhood, but is limited by the pathology and the degree of success following operations. To scientifically recommend surgical interference, we must be sure of our diagnosis, and permit of extreme limits in our prognosis.

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#### EFFECTS OF AN OVERDOSE OF CODEINE.

An overdose of codeine is not a common occurrence, and therefore Dr. Mettenheimer, who has met with such a case, has reported it. An elderly lady consulted him for a slight catarrhal, non-febrile affection which, however, gave rise to a troublesome, spasmodic form of cough. For this he prescribed 0.03 grammie (about half a grain) of phosphate of codeine, in the form of a pill, to be taken every three hours. The patient, however, swallowed four of these pills, or about a grain and a half of the codeine salt, at once. Shortly afterwards she vomited twice and suffered from abdominal pain. There was, too, suppression of urine and she felt very ill, being sleepy but unable to go to sleep. The next day she was still drowsy and had no appetite but there was no return of the sickness. She was then seen by Dr. Mettenheimer, who found the pupils contracted, the pulse hard and quick, and the respiration accelerated. The cough had entirely disappeared. The contracted state of the pupils, the loss of appetite, and the abdominal pain persisted for several days. No urine was passed until thirty-six hours after the pills were taken. On the third day the drowsiness had passed away. The cough did not return for a week and when it did it was comparatively slight. This case seems to show that codeine in large doses has a very similar effect to opium and that it may prove a most efficient remedy for some kinds of cough. As the tongue remained clean it would appear that the vomiting was due to cerebral, rather than to gastric, irritation.—*Lancet*.

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## TYPHO-MALARIAL FEVER SO-CALLED.

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In presenting this paper I shall claim no originality, nor attempt to produce anything new. The nomenclature of this disease is quite varied. Wood calls it "entero-miasmatic;" Drake gives it the name of "remitto-typhus;" Loomis calls it "continued malarial fever," and Woodward gave it the name "typho-malaria" by which it is best known through the Southern States. I believe that all of the above appellations are erroneous and misleading.

During the four years of my professional life it has been my good fortune to meet with and treat at least ninety cases of this fever that could easily be excluded from all other well recognized diseases. All of these cases were well developed, presenting well marked symptoms characteristic of this, so-called "typho-malarial fever." Doubtful cases were omitted. I shall give only the leading symptoms of this disease as I observed them, for I hope not to bore you by presenting facts with which the greater majority of this Association are already so well acquainted.

My experience with this disease leads me to believe: (1) That this fever occurs most frequently in the last month of summer and in the three fall months.

2. It occurs usually in the young and middle aged, very rarely in the aged.

3. The disease is very rarely found among the African race.

*Symptoms.*—The patient usually complains for a few days of being weak and of his head or back aching. Then perhaps he will have a chilly sensation with high fever following. The temperature course reaches its maximum, most usually, the first or second day. Then it will drop perhaps a degree or two and continue at this stage for from two to five weeks, I have had a few cases that had fever for six weeks. The pulse and temperature usually preserve a normal ratio. Sometimes we have diarrhoea, but most generally constipation. When diarrhoea occurs it is easily controlled by judicious treat-

ment. There is nothing especially characteristic about the stools as observed without the microscope. Occasionally we have a case with a little tympanites. No tenderness nor the characteristic gurgling of typhoid in the right iliac region. No rose colored spots. The urine is always scant and usually high colored, but not turbid. It was not tested by the microscope. The middle and back part of the tongue is usually coated by a light fur, sometimes there is a yellowish white coating. The papilla of the tongue is almost always very prominent, its tip red and strawberry-like. Sometimes edges red. Often it is considerably pointed, at others quite flat and flabby. No sordes on the teeth; gastric disturbances usually occurred in children, not so frequent in adults. When delirium occurs it is most usually during the first few days when the fever is highest. Occasionally we have hepatic tenderness and vomiting of bile. No subsultus tendinum. The only special symptom after the first two or three days of which the patient complains is that of a general feeling of exhaustion, as if they were "completely worked down." It is not often that they complained of inability to sleep and rest at night. This is very striking in the great majority of cases; sometimes it is the reverse. Out of ninety cases I lost two; one died from hemorrhage of the bowels, the other from heart failure. My treatment is generally expectant. I know of no specific, nor any regular course of treatment like we have in malaria and typhoid. I usually open the bowels with a small dose of calomel followed by a gentle laxative. In my first experience with this fever, I pushed quinine, thinking that it was of malarial origin, but without effect. I have never been able to attribute any good results to this drug in treating this disease. Nitromuriatic acid is a great favorite with me in treating such cases, it aids digestion and assimilation. Sometimes if a dry tongue and tympany develop I give turpentine emulsion. My experience with this disease is that we must guard against heart failure. There is almost always a great "prostration of muscular strength." Even in the mildest cases it is some weeks before the patient regains his former strength and power. The muscles of the lower extremities seem to be especially affected in this fever. To see a patient

\*Read before Tennessee State Medical Society, April 1892.

when recovering attempting to walk reminds me of that muscular prostration following diphtheria. For the cardiac weakness, I sometimes use digitalis, oftener during my former experience than during the last year. As Dr. H. C. Wood states, so I believe, that in a great majority of cases it "impairs the irritability of the sensory and motor nerves and muscular fibre, and interferes with reflex actions, effects that cannot fail to retard nutrition."

When I find the capillary circulation slow, the pulse very fast and weak, and other symptoms "evincing depression of the excito-motory nervous centres," I generally give strychnia. Alcoholic stimulants are also used with splendid effects in such cases. I have now given the most prominent symptoms of, and my general course of treatment in, the so-called typho-malarial fever. The symptoms of this fever, as I observed them, clearly simulate the description of the so-called mountain fever of Colorado, given by L. Hubers M. D., of Rockyford, Colorado, in *The Medical News* of September 20, 1890. I believe the two fevers are produced from the same poison, the apparent difference being due to climate, altitude, etc. In speaking of this fever he says: "I am quite certain that I first observed cases of the so-called mountain fever in the Arkansas River valley in Western Kansas. There it was not known by the above appellation, nevertheless, several years' experience with the disease convinces me of its identity with 'mountain fever.' Dr. Huber does not tell us what this fever was called in Western Kansas, but from his description I understand that it was the so-called typho-malarial fever.

My principal object, as stated above, in preparing this paper is, that I desire to state my lack of faith in all former theories of this disease, with one exception. The theories as presented to the profession heretofore are about as follows:

1. That it is a hybrid disease.
2. That this so-called typho-malarial is a mild manifestation of typhoid.
3. That it is a combination of both the typhoid and malarial poisons.
4. That it is "a distinct type of specific fever."

In answering the first theory it hardly becomes necessary to state that we have no such thing as a hybrid disease. No really

scientific investigator has ever come to such an irrational conclusion. All standard authorities assume that it is no hybrid; neither do I believe this to be a mild form of typhoid. All who take this view have so far furnished us with but little proof to substantiate their position; their arguments are by no means complete or convincing. It has been more of the nature of assumption than proof. They have not attempted to prove their affirmation by bacteriological investigations, nor from the pathological anatomy in such cases. Even the eminent Loomis (*Practice of Medicine*) in his concluding remarks on the morbid anatomy of this disease, says: "While therefore no pathological lesions which can be regarded a characteristic of this type of fever are found, and while the lesions very closely resemble those of typhoid fever on the one hand and remittent fever on the other, still there are differences which are sufficient to distinguish it from both and to stamp it as a distinct type of fever. By far the ablest plea for its being a mild type of typhoid was presented in the *Medical News*, of June 12, 1890, by Dr. W. W. Johnson, of Washington City. He seems to take it for granted that it is the result of the typhoid poison, and fights for his theory on the defensive order in endeavoring to exclude the malarial poison. He says in his argument for the exclusion of the latter poison, "The strongest arguments for the theory of the two diseases in one individual, are the presence of supposed well defined malarial symptoms in typical enteric fevers, and the beneficent effects of quinine in such cases. "To the first of these arguments it may be answered that the occurrence of chills in the onset or during the course of enteric fever, marked remissions in the fever curve, gastric irritability, the vomiting of bile, icterus and hepatic tenderness, are not necessarily due to malarial infection, and may and do occur in the course of the enteric fever of localities where malaria is unknown."

To the second argument, I will state that in my experience quinine has had no control over this disease whatever. It has not influenced the course or duration of a single case, to my knowledge. Dr. Johnson says that the symptoms so closely simulating those produced by the malarial virus are not necessarily due to this poison, for the reason that such conditions are

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present in diseases where we know there is no malaria present, why not put the typhoid virus to the same test for exclusion in this disease. Do we not often find in many other diseases symptoms simulating those of typhoid fever where we have every reason to know that the specific virus is absent?

There is rarely the distinct pathological lesion of typhoid, neither is there anything characteristic about the stools from a bacteriological nor pathological investigation. Then why do so many of the profession continue to call this modified typhoid when they have so little grounds for so doing.

The third position I believe to be as fallacious as the other two. It is hardly reasonable to suppose that we have a mild form of fever produced by the preying upon the system of two distinct poisons. At the same time, I think that we have clearly proven that there is at least room for skepticism in regard to the presence of the typhoid virus in this disease, even from the confession of those who believe it to exist, and we think it just as unreasonable to claim the presence of the malarial germ as that of the typhoid poison; however, I believe the larger majority of textbooks take the position that in this fever we have the malarial agency; and that it is really "modified malarial fever" instead of "modified typhoid fever." Dr. Bartholow does not think this a distinct type of fever simply typhoid complicated by malarial poison. Dr. Sam. M. Bemiss, of New Orleans, in Pepper's System of Medicine, vol. 1, page 614, in speaking of this fever says: "The prefix *typho* is properly applicable to a class of malarial fevers which are complicated by the specific poison which produces typhoid fever," and that the term (typho-malarial) should be so restricted as to define a disease compounded of the two pathological factors which, when acting separately, produce either typhoid or malarial fever." We think this is a definition calculated to mislead. Dr. Bemiss does not bring forth any very convincing proof to show either the presence of malaria or typhoid. He seems to take it for granted that "these things are so."

The presence of malaria is not evinced from the pathology of the disease so far as I have been able to ascertain. The effects of the anti-malarial treatment as

advised by most authors does not go to prove that the malarial virus is present.

We believe that our authors of the present day too often receive the tradition of our forefathers and jump at conclusions in regard to the *aetiology* of this disease. They take too much for granted and are too easily convinced of the presence of certain poisons merely from physical signs. To show you the truth of the above assertion, I wish to make a quotation from the clinical lectures of Dr. Nathan S. Davis in his lecture on "Continued Fever." In presenting to his class a certain case of fever, he states: "The early history of the case (a chill followed by a paroxysm of fever) together with the existing pallor of skin and exacerbating character of the febrile phenomena *show the existence of a malarial influence.*"

Is this proof sufficient to convince a thinking mind that the malarial parasite was in the blood of this patient beyond any question? Might not some septic poison produce the same symptoms.

In diagnosing for a tuberculosis are we content with simply the physical signs? Do we not search for the tubercle bacilli, the morbid anatomy and other corroborating conditions? In answer to a query in regard to typho-malaria," Dr. H. Toulmin, of the John Hopkins Hospital says, in regard to the two diseases being blended together, "that malarial fever and typhoid fever are entirely and perfectly distinct and are never found in combination. . . . We always examine the blood for Laveran's organisms, and test the urine for Erlich's typhoid reaction, which we consider of much value."

We might add that this is the verdict of the best authors from their most recent investigation.

If it be true that we have a modified form of either malaria or typhoid the one by the other, I would like to ask a few questions under the light of Laveran's discovery, pointing to the possibilities of a wonderful revolution in the treatment of malaria and typhoid.

1. If both the malarial parasite and the typhoid virus exist in these cases, why have they not been found in the blood of those persons thus affected? Laveran claims that, "the malarial parasite has never been found in the blood of those not affected with malarial poison." Again, the same investigator says: "The salts of qui-

nine cause the parasite to disappear from the blood, and this takes place synchronously with the cessation of the fever."

We found that in the above ninety enumerated cases that the salts of quinine did not have this effect in a single case, therefore we are forced to conclude that the malarial parasite was absent.

Dr. Osler states that "The characteristic changes in malaria are as distinctly determined in the blood as are those of tuberculosis of the lung in the sputa."

Dr. George Dock, of Galveston, Texas, has made some very interesting investigations along this line corroborative of Osler's statement.

2. If the malarial parasite modifies the action of the typhoid poison why not convert a specific typhoid into a so-called typho-malaria by injecting into the blood of the typhoid patient the malarial parasite. By this means we would lessen the mortality. It seems to me that this would be easily accomplished if the theory be true for the great Laveran again asserts that "malarial disease has been transmitted from one person to another by injecting into the veins of a non-malaria individual a small quantity of blood containing the parasite."

In regard to the fourth theory, that it is a distinct type of specific fever, I am well convinced that this will be the final conclusion of all true pathologists and bacteriologists.

Dr. J. S. Cain, of Nashville, Tennessee, in the last December number of *The Southern Practitioner*, was the first to boldly advocate the specific nature of this disease. He says: "That it is a distinct type of specific fever bearing no relationship to typhoid and no similarity further than its continuousness and none whatever to malarial fever." He believes that it is produced by a septic agency. Be this as it may, for a final solution of this question we await the future developments of the microscopist.

#### TO RELIEVE HEADACHE.

Weiss (*Prager med. Wochenschr.*, No. 15, 1892, p. 159) has observed that temporary relief from headache could invariably be afforded by pressure upon the abdomen at a point midway between the umbilicus and the ensiform cartilage, the mechanism of which is thought to be dependent upon compression of the aorta.

#### THE TRUE PATHOLOGY OF SUDEN DEATH IN ACUTE PNEUMONIA, AND THE BEST MEANS OF AVERTING IT.\*

BY CHAS. F. J. LEHLBACH, M. D., NEWARK, N. J.

The committee on business of last year, in formulating this subject for discussion, have undoubtedly sought to limit it to those cases of sudden death in acute pneumonia which seem to be disconnected from any pre-existing or merely accidentally intercurrent fatal morbid process, or complication. A patient passing through acute pneumonia, with previously existing chronic degenerative nephritis may suddenly be seized with uræmic convulsions, coma, and death; or a sufferer from chronic rheumatic endarteritis of the cerebral vessels may during a fit of coughing in pneumonia be attacked by a sudden cerebral haemorrhage and die. Such cases do not enter the present inquiry. Their pathology is beyond controversy and there is no preventive means, which may reach them, within our present knowledge.

The class of cases under discussion can best be exemplified by the short recital of one typical case, that of our lamented friend and colleague, the late Dr. Woodhull, of Newark, for a history of which I am indebted to the kindness of Drs. Edgar Holden and Charles Young.

This is Dr. Holden's statement:—"Dr. Addison W. Woodhull, born August, 1831. Died in the Spring of 1876, age 45. One morning he said to me on the street: 'I have a very annoying pain in my left side to-day; I wonder if my old wound is going to trouble me.' He went to New York and before his return took a Turkish bath, and on his return home felt miserable but went on with work; was taken at night with a chill and slight dyspnoea; this was followed by fever, cough and soon rusty colored sputa. Dr. O'Gorman and myself attended him; rapid consolidation of the lung (I think the left) followed.

"The disease ran the usual course of a unilateral pneumonia in a man with sound heart, for I examined not only then, but I before had examined him for life insur-

\*Read before Medical Society of the State of New Jersey.

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ance, and at that time found no impairment of any organs, save the left pleura thickened and adherent where he had been wounded. My impression is that the chest wound involved only the thoracic parietes, including the pleura but not the lung.

“At about the end of three weeks he was so far convalescent that we said at our morning visit: ‘You will not need us any more but we will drop in occasionally to see how you regain strength.’ He was able to sit up several times through the day and felt well, had return of appetite, but remarked every day that he could not understand the continuance of the stained sputa. This, from the second day of its appearance, had been not simply rusty, as is usual, but quite red, indeed at times almost jelly-like, and we had frequently discussed the significance of it; but the most careful daily examination had failed to detect any symptom or abnormal sound, rate or area of dullness not perfectly consistent with the diagnosis of acute unilateral pneumonia. We left him on Sunday morning, he saying ‘I will be out in a week at the most, and feel well enough to go now.’

“Upon returning from professional calls, I found an urgent message to go to him but found him dead.” The following is Dr. Young’s statement:

“While passing through Kinney street near Dr. Woodhull’s residence, I suddenly heard my name called loudly, and, turning around saw the call came from Dr. Woodhull’s house. Rapidly entering I saw the patient within ten minutes, probably less, after the first seizure, which was described as follows: The patient had been sitting up by the window, when he suddenly complained of feeling faint, without any pain, and was assisted by his wife to bed, when he became immediately unconscious, with slow difficult respiration and rapidly cyanosed. When seen by me he was in this condition with hardly any pulse, deeply cyanosed, irregular and slow respiration, eyes rolled upward out of their natural axis, insensible to light; no sign of any convulsive movement. Recognizing the extreme condition of the patient, a free hypodermic injection of ammonia was given with a view, if possible, to stimulate the heart and of its alkalinizing effect upon the blood. Within a very short space of time, the cyanosis began to fade and disappear from the forehead

down, so that the face assumed a natural hue; the respiratory rhythm was re-established, the pulse came up, so that it became at least distinctly perceptible.

“This condition of apparent reaction, without, however, any sign of returning consciousness (at least as far as muscular manifestations or impressions were concerned) continued for a short time, almost giving hope of a chance for life, but soon he relapsed into the condition, in which he was first found and died.”

No autopsy was made. Indeed the absence of records of post-mortem examinations in these cases of sudden death in acute pneumonia forms one of the difficulties in arriving at positive conclusions as to the cause or causes. The clinical history of these cases leave no doubt as to the diagnosis. A fatal termination is to be expected in a certain percentage of cases of acute lobar pneumonia under any circumstances, a larger proportion occurs in private practice, where the surroundings and other considerations of sentiment or convenience forbid the urging of autopsies as matters of simple scientific interest, and thus in most cases we are satisfied with crediting the sudden fatal termination to any of the various lesional possibilities that may occur in pneumonia by embracing them all under the term heart failure. But, does this explanation explain? Heart-failure as a true direct cause of death can happen in two ways; either by sudden paralysis of innervation through the branches of the pneumogastric nerve supplying it or the inhibitory-ganglia regulating it; or by structural degenerative changes in the heart muscle itself; in the one case the motor power being lost, in the other the motor machine refusing to act, being worn out. Discarding, hence, the term heart-failure as a pathological entity in explaining sudden death in pneumonia, we are forced to look elsewhere. As a guide in which direction to search for the cause or causes two facts should be borne in mind:

1. That these cases of sudden death under consideration, generally occur during or after apparently fully established convalescence, and

2. That the fatal attack is ushered in suddenly and terminates fatally under tumultuous signs of a struggle between the heart and lungs, indicating plainly the sudden occurrence of mechanical obstruc-

tions in the right heart and pulmonary circulation, as shown by the weak and imperceptible pulse, the dyspnoea, irregularity of respiration, the intense and rapid cyanosis, and unconsciousness.

Of all the authors of treatises on pneumonia in the various text-books, so-called, accessible to me the one who comes nearest to a full appreciation of the true cause of this class of sudden death is Flint. He says: "There is a liability in the course of this disease to an occurrence which claims special notice, namely, coagulation of fibrin in the right auricle or ventricle; that is to heart thrombus; this is of not infrequent occurrence in fatal cases of pneumonia. It occurs especially when an entire lung becomes involved, and in cases of double pneumonitis."

"Thrombi formed ante-mortem and not infrequently the immediate cause of death, are to be distinguished from those produced in the last moments of life and from post-mortem clots. Their formation sometimes may be determined and with much confidence during life. In a case presenting no symptoms which denote imminent danger a sudden change takes place for the worse; the circulation is notably disturbed as shown by the frequency, feebleness and irregularity of the pulse; there is a sense of the want of air; the expression is haggard and anxious, cyanosis is more or less marked; the patient falls speedily into a moribund state; and this unexpected change is not connected with an extension of the disease to a new lobe or any newly-developed inflammatory complication."

Assuming then that Flint is correct in ascribing heart thrombus as a not infrequent cause of death in pneumonia, although no special emphasis is put on "sudden death" during apparent convalescence, let us extend our inquiry a little further by including embolism of the pulmonary vessels with heart thrombus, or vice versa. If they are found to be the cause of sudden death in numerous and varied other pathological processes there is, for very good reasons to be alluded to further on, no ground to doubt that we here have the principal cause of sudden death in pneumonia. It is not intended to go into an elaborate or exhaustive examination of details. A few facts obtained by a cursory examination of accessible records will illustrate the subject.

Dr. Raywood Johnson in the transactions of the Path. Soc., London, 1889—(*Schmidt's Jahrb.*, Vol. 229, p. 249,) describes the case of a woman fifty-four years old, with varices of leg and phlebitis, who died suddenly in an attack of dyspnoea, of embolism in the pulmonary artery, six to seven inches in length, resting on the bifurcation.

A case of sudden death in a case of typhoid fever by embolism of the pulmonary artery is reported from the *Prager Vierteljahrssen*, in *Schmidt's Jahrb.*, Vol. 228, p. 215. Autopsy showed tolerably coherent coagula in the main trunk of the pulmonary artery.

A case of sudden death in consequence of formation of thrombus in the pulmonary artery, occurring in a case of acute exudative pleuritis is reported by Dr. Du-jardin Beaumet in *Gaz. de Paris* (*Schm. Jahrb.*, Vol. 171, p. 150) death occurred when patient got out of bed to go to stool.

In a paper on sudden death by pulmonary embolism in cases of inflammatory varicose veins, Dr. Marc Chabenat, of Paris, (1874) collected seven (7) cases. In five (5) cases the autopsy showed presence of emboli in the right heart and trunk of pulmonary artery; in the other two cases no autopsy was made, but the history of the case was clear as pointing to the same causes. The author calls attention to the fact that the neighborhood of large venous trunks in which the blood flows yet uninterruptedly favors the detachment of an embolism. In all these cases the emboli were large, as large as a finger, and the detachment of the emboli always took place in the convalescent stage on occasion of sudden movements in bed or when getting out of it.

Two cases of sudden death from embolism and thrombus in the pulmonary artery are reported (*Bullet. de la Soc. Anatom.*, in *Schm. Jahrb.*) due in one case (Dr. Cossy's) to inflammation of the crural vein after operation for strangulated hernia; in the second case, reported by Dr. Heger, due to thrombosis of the left femoral vein after enucleation of a uterine myoma.

Spontaneous extensive thrombosis of the pulmonary artery caused sudden death in a young chlorotic girl, after a short attack of dyspnoea. Reported by D. H. Rendt, (*Gaz. Hebdom.*, XXXIV, 16, *Schmidt's Jahrb.*, Vol. 215, p. 249). Embolism excluded.

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In his inaugural dissertation, Dr. B. L. B. Bang (*Afhandl. für Doktorgraden, Schmidt's Jahrb.*, 1882, vol. 195, p. 289) a study of twelve cases of embolism or thrombosis of the pulmonary artery concludes that the most dangerous, i. e., the large emboli, mostly occur in the cases in which the clinical histories show no sign of presence of pre-existing cause.

In a paper on "Sudden Death in Pleurisy" by D. E. Weill (*Revue de Med.*, vol. VII, p. 33, *Schmidt's Jahrb.*, vol. 214, p. 30) the author collects twenty-seven cases of sudden death in pleuritis; in eleven of these cases there was thrombus-formation in the right heart and embolism of pulmonary artery or changes in the myocardium; in six, oedema of the lungs; there was one of pericarditis; in two perforation took place into the lung and in seven cases the autopsies showed no certain cause of death. These latter may have been due to direct heart failure or brain anaemia. In most of these cases death occurred after strong muscular movements—only three died while quietly lying in bed.

Prof. Adolf Lesser of Breslau, in *Vierteljesch fuer faren Mediz.*, *Schmidt's Jahrb.* vol. 219, p. 74, gives the most important autopsy results in 171 cases of sudden death; only in fifty-three cases an anatomical cause for the suddenness of death was reached; in twenty-one cases there were pressure upon the brain, apoplexy, tumors, haemorrhage, aneurism; seven were cases of cardiac aneurism; eight times there was suffocative haemoptysis and bursting of aneurism into trachea; in seventeen cases aneurism was the cause accompanying the fatal result; six were caused by embolism of the pulmonary arteries; in seven cases genuine pneumonia existed, where no direct cause could be found.

In the Medical and Surgical History of the War of the Rebellion, Part 2d, Medical Volume, under the history of acute diarrhoea among the post-mortem appearances noticed, special mention is made of over thirty-six cases in which "fibrinous heart-clots with or without an admixture of ordinary coagula were observed." Two of these cases are noted as having died "very suddenly" and "suddenly." One of these cases died suddenly of pneumonia, and in looking over the details I find that eleven of these cases of heart clot and clots in the pulmonary arteries credited to acute diarrhoea were shown by the autopsies to

have been complicated with pneumonia in various stages of progress and intensity, namely cases 162-330-352-353-360-377-385-412-525-642-749.

A cursory examination of the details of cases of pneumonia given in vol. 3d of the same work, is negative as to the occurrence of ante-mortem thrombosis or embolism and their bearings to sudden death.

If we assume then, that thrombosis or embolism of the heart and pulmonary arteries constitute the true pathology in a certain number of cases of sudden death in pneumonia, as well as in other diseases—an assumption based upon undoubted facts—we are naturally and logically led to enquire whether the pathological processes and conditions of pneumonia are favorable to their occurrence. Such seems to be the case.

Aside from the undoubtedly increase of fibrin in the blood in pneumonia, as in acute rheumatism and erysipelas, and its probable greater tendency to coagulation, the pathological processes going on in the minute structure of the lungs in pneumonia themselves are not unfavorable to the occurrence of thrombi and emboli. When the air spaces and bronchi have become fully distended by the exuded inflammatory products and the lung has become solid, when the air vesicles, the air passages, the small bronchi and sometimes the large bronchi are filled and distended with fibrin, pus cells, red blood cells, and epithelium we are told by Delafield and Prudden (*Hand-book of Pathology*) that "in spite of the pressure on the walls of the air spaces, the blood-vessels in their walls remain pervious." Hence if even a very minute thrombus shall have accidentally formed in one of the small branches of a pulmonary vein, entering into the formation of the vascular network surrounding the air vesicles, this very fact stated by the eminent pathologists cited "that the vessels remain pervious" would favor its detachment and chance of entering the current of blood into the right auricle, thence into the right ventricle, there to become entangled in the pectinated muscles or tendinous chords and to form the nucleus of a rapidly enlarging embolic clot extending, as the case may be, way into the pulmonary arteries up to the bifurcation, and leading to sudden death.

Another point in the clinical pathology of pneumonia, particularly in infectious pneumonia, which would favor cardiac thrombus and embolus, is the concurrence of endocarditis with the pneumonia. A moderate degree of endocarditis is, I think, a much more frequent companion of inflammation of the lungs than is generally supposed and than it is possible to clinically prove in all cases. "So long" we are told by Delafield and Prudden "as the endothelial linings of the vessels are intact, a simple retardation of the circulation does not usually suffice to induce coagulation, but changes in the endothelium from a great variety of causes, such as inflammation, degeneration, atheroma calcification and the presence of tumors and foreign bodies favor its occurrence." Thus we see that the existence of endocarditis would favor coagulation.

From what has thus far been stated, it is obvious that whatever means of averting sudden death in pneumonia we may employ, they can only be general and precautionary. The patient should be warned even after the temperature has become normal, not to adopt too soon the habits of fully established convalescence. In fact, he should not be allowed to undergo any muscular exertion or bodily effort, not even the passive one of sitting up, until the expectoration has become of a character to show that the exudative process has entirely ceased and that the degenerative changes in the exudate, necessary for its removal are about completed. The presence or absence of blood, or of its elements in the expectoration may probably be considered an important guide in this direction. Remedial agents should be employed to allay the severity of the cough with its danger that by mere mechanical concussion of the solidified lung any little thrombi in the pulmonary veins may become detached and enter the current of blood toward the heart and resulting in cardiac embolism and emboli of the pulmonary arteries. Ammonia in one form or another should be given during the whole progress of the disease, not only as one of the most valuable heart stimulants that we possess but also to counteract the tendency to coagulation and the hyperinosis, or increase of fibrin in the blood of pneumonia patients. For the suggestion of the probable good effect of ammonia to counteract the tendency to

hyperinosis in pneumonia, I am indebted to my friend Dr. Charles Young. As to the particular preparation of ammonia to be used there may be little choice; but during the last few years my own predilection has been in favor of ammonium salicylate, as it combines the stimulating effect upon the heart with the action of a general blood antiseptic, in cases of infectious pneumonia, and also on account of its good effect in rheumatic endocarditic complication. It can be simply given in ten grains doses every two to four hours.

Having thus opened the discussion on this interesting subject, while I beg that you will pardon me for not having laid before you a more elaborate study, I hope also that you will agree with me, when I say that it should be our duty in every case of sudden death in pneumonia to insist upon a thorough and minute autopsy so that we may know the cause rather than to guess at it.

#### DOUBLE HÆMORRHAGIC SUBDURAL CYST.

Dr. Newton Pitt showed a double hæmorrhagic cyst before the Pathological Society of London, which was taken from a man aged forty-six, who had suffered for eighteen months with frontal headaches; at night he occasionally had twitchings on the right side. The twitchings were more frequent two weeks before his death; he then became dull, apathetic and increasingly comatose. At the inspection two thin cysts were found in the frontal region in the subdural space, with walls formed of embryonic vascular connective tissue,  $\frac{1}{4}$  mm. thick, containing on the right, six ounces, and on the left, three ounces of serous fluid with recent blood clots. The dura mater was not inflamed. The cysts were attached to the dura mater, but not firmly, and were not attached to the brain. The inner surface was as smooth as that of normal dura mater. The case was a typical example of those cysts whose hæmorrhagic origin was first clearly demonstrated by Mr. Prescott Hewett in 1845. The sources of the hæmorrhage in such cases are from the degenerate cerebral veins in the wasted brains of general paralysis; from either the dura-mater or the pia arachnoid when due to typhus, relapsing fever, and similar conditions producing degeneration of the blood.—*The Lancet*, Nov. 8th, 1891.

September 3, 1892.

## Communications.

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## COMMON BOILS AND CARBUNCLES.

By P. J. FARNSWORTH, A. M., M. D.,  
CLINTON, IOWA.

Early in my practice I stumbled on a successful course of treatment for aborting boils and carbuncles in their early stages and of conducting them to a speedy and painless consummation if not seen until well started.

In the later discoveries of science I have found the reason for my treatment and abundant justification.

If my attention is called to the disease in its pustular stage I apply *unguentum hydragyi*. If they are occurring in a crop several applications are made to a considerable surface. This prevents their recurrence, and aborts those underway. If the boil is fairly begun, is congested, cyanosed and throbbing, "a blue boil" I apply a plaster of *gum opium*. The gum moistened and spread on a cloth or the powder mixed with cerate. In a short time the throbbing ceases, the congestion is removed and in a few hours a circumscribed suppuration takes place (comes to a head at once), the core or nidus comes out. An antiseptic wash soon completes the cure.

If the pustule is judged to be a carbuncle, a plaster made with mercurial ointment (*ung. hydry.*) and powdered opium is applied, which either checks it in the start or converts it into an insignificant affair, soon maturing.

It has been recommended to introduce into the boil, in its early stage, an injection of carbolic acid. This has been successful but is quite painful. Cocaine has been suggested, but the same objection holds. A strong solution of hydr. bichl. 1 to 100 applied to the pimple or pustule is more effectual and produces little pain. It acts in the same manner as the mercurial ointment, destroying the microbe. The injection does not always strike the nest.

In some cases a plaster of extract of belladonna, if far enough from the place not to affect the eyes, acts as well as the opium. The effect is to tranquillize the nerves and also to narcotize and prevent the propagation of the specific microbe.

My first case was a lady, past middle life, of rather broken down constitution, I found a crop of boils covering her back and shoulders, thirty or forty in number, from the size of a pea to that of a walnut. The pain and irritation was intense. She warned me not to give her an opiate, as that would only add to her suffering. Calling for some lard I mixed with it half an ounce of pulverized opium spread it on a cloth and applied it to the back. It soon produced relief. I left with directions if any signs of narcotism appear to remove the plaster and wash the surface clean.

When I returned the next morning the patient was sitting up in an agreeable frame of mind, having enjoyed a pleasant night's rest and showing no signs of narcotic effect or sequela. On removing the dressing I found the surface whitened, and most of the boils open and suppurating. A linseed poultice was then applied and in a few days the patient was well. It seemed at the time a life-saving application.

Since then I have never met so large a number together but have put on the opium plaster on single ones many times with the same good results. To the boils recurring in the vicinity of one that has seen its course, apply the mercurial ointment. If they are scattered over the person use on them, if seen early enough, the unguentum hydrg., or the solution of the bichloride, to abort them. If they have passed this point apply the opium plaster or the belladonna. If the system is in bad condition give constitutional treatment—mercury in small doses, tonics, iodides and sarsaparilla.

The carbuncle requires a more vigorous treatment. The crucial incision, if far advanced, and the ointment or wash of mercury. If in the early stage, apply opium mixed with the mercurial ointment. In either case when the opening comes use a syringe and wash out the cavity thoroughly with a mild bichloride solution or a strong one of carbolic acid.

The application of opium to an inflamed surface may be much more extended. It relieves the pain and prevents the spread of traumatic erysipelas, and is valuable in burns and extensive ulceration. A poultice or fomentation as commonly used is a germ disseminator and cultivator. For open sores apply a cirate of opium and a covering of absorbent cotton. Fomenta-

tions are useful in deep seated phlegmons but when near the surface apply the opium as a plaster or cerate.

Very little of the active principle is absorbed through the skin or from an inflamed surface, to affect the nerve centers. Its effect, however, over inflammation is remarkable. It is more than probable that to this probably may be attributed its influence in peritonitis. It not only quiets the brain but the nerves of sensation and prevents or checks inflammation. Opium is admissible in inflammations of any part except of the bronchi, with equally good effect.

#### RETAINED PLACENTA: EFFECTS OF ATMOSPHERIC PRESSURE.

Cavilan, of Durango, Mexico (*Arch. de Tocol. et de Gynéc.*, March, 1892), attributes retention of the placenta to atmospheric pressure. His father, in the course of a large practice, only met with one case in thirty-five years of true, adherent placenta. He maintains that all the morbid conditions which might cause adhesions, such as uterine inflammation and placental apoplexy, produce abortion before any firm adhesions could be established. The common so-called "adherent placenta" represents an effect of atmospheric pressure. The central part of the placenta is first detached, and thus between the uterus and the maternal aspect of the placenta a vacuum is formed, the placenta being in the mechanical condition of a cupping-glass. Its edges are firmly pressed against the uterus. Pulling on the cord simply encourages the development of the vacuum. Abuse of ergot does the same kind of harm. Credé's method of expression prevents or overcomes the vacuum. When the placenta is distinctly "adherent," the vacuum must be destroyed. Cavilan acts in the following manner. The midwife or assistant pulls the cord firmly, obstetrician steadies the fundus with the left hand and perforates the placenta, close to the cord, with the right fore and middle finger. As the uterine tissues are far tougher than the placental tissues there is no fear of perforating the uterus with the fingers. The air then enters the vacuum and the placenta can easily be detached. The strongest antiseptic precautions are necessary during this manœuvre.—*Brit. Med. Jour.*

## Hospital Reports.

### BRAINARD MEDICAL SOCIETY OF WISCONSIN.

This Society recently met in Chicago, and devoted part of its session to attending the following clinics at Rush Medical College:

#### CLINIC ON PRACTICE.

Prof. Henry M. Lyman, speaking on massage, explained that it was not, as was so generally believed, a process of rubbing, but rather manipulation, and to better illustrate this had a patient brought to the amphitheatre to be massaged by a professional masseur. The professor explained that massage should always be commenced at the extremities, working toward the body, care being taken that every part of the limb be treated.

The Professor lauded its action in inducing contraction of the arterioles and thus accelerating the circulation, improving the nutrition of the parts, stimulating absorption and increasing secretion from the various organs.

It is in patients run down by pressure of business, etc., that we often prescribe travel, and this in patients who can afford the time and money is very well; but Doctors should not prescribe things that cannot be done, and it is in these cases that massage came as a boon, as it could be afforded by every one; it required but an hour every other day to get its benefits. It was wonderful how these patients, run down and exhausted, picked up, their appetites increasing, insomnia disappearing and the general circulation improving even after using it only for a short time. In continuation of the clinic a number of cases were brought in suffering from central nerve lesions. Two children suffering from the effects of poliomyelitis, one little girl, about 13 years old, suffering from mobile spasm or athetosis, and a little boy suffering from epilepsy, with attacks of mania following the epileptic attacks.

The histories of the cases of poliomyelitis were read by Dr. Cleveland which were similar to all these cases, the one lower extremity in each of the children was atrophied and shortened. The girl with athetosis gave no history of injury or prior disease of the brain or its envelopes. The

spasm of fingers and hand were very characteristic. In speaking of the seat of the trouble in these two groups of cases the Professor explained that in the cases of poliomyelitis, the lesion would be found in the cord, while in the case of mobile spasm it would be found in the brain, either in the thalamus, the lenticular nucleus, or somewhere in the gray matter of the pyramidal tract.

In the former cases judicious treatment should be followed by improvement, while in the latter, treatment on account of the nature and seat of the lesion, precludes their removal by remedial agencies.

The case of epilepsy was rather rare on account of the maniacal attacks following the epileptic attacks, as in most cases they precede the same. The patient kicks and bites and would destroy anything that happened to be in reach during these attacks, although perfectly harmless at other times. He has a history of insanity, as his father is insane. The Professor explained how these patients might become criminals, committing even homicide during these attacks, and yet be perfectly unconscious of the fact.

Some such patients would travel to a distance behaving well and having an attack of epilepsy return to consciousness, perfectly unaware of the just preceding acts, this might even lead to a dual life of the individual.

#### SURGICAL CLINIC BY PROF. N. SENN.

Prof. Senn in his clinic presented a number of cases, that had been operated on the last few weeks.

The first case to which attention was called was a laparotomy for the purpose of removing a fetus in the free abdominal cavity. It had been there dead for some years. The fetus at the time of death must have been about seven months old. In making the operation the placenta was found to be nearly absorbed, and what remained was therefore not removed, trusting that the remaining part would be absorbed, as the absorbing power of the parts would be increased by the removal of the fetus.

The patient and the fetus were shown; the patient had made an uninterrupted recovery, temperature normal after first day. The Professor thought that notwithstanding Tait, he thought this case showed that the embryo could and did de-

velop in the free abdominal cavity, as no symptoms of rupture could be elicited.

A case was next shown in which an operation for a large ventral hernia had been made with splendid success, the cicatrix being perfectly firm, and yet the Professor would advise her to wear a pad for some weeks as these cicatrices were always treacherous.

The next case was one that had suffered from pyelonephrosis and had been operated upon some weeks ago. The interesting part in the case was the large size of the stone that was found perfectly impacted in the pelvis of the kidneys, so that it was with great difficulty removed. The Professor laid great stress on his advice not to crush or break up such a stone, but to remove it whole even if the tissues should receive a little more injury, as through crushing, the liability of leaving pieces of the stone is great, which would merely serve as a nucleus for a return of the whole trouble.

The next case shown was one of nephrectomy that had been performed some time ago. In this case the occlusion of the ureter had dated back eleven years, it was therefore reasonable to suppose that the kidney structure had all disappeared, and on removing the kidney, it was found to be atrophied to the thickness of cardboard, perfectly translucent and yet Professor Senn was surprised to find on microscopic examination healthy kidney structure atrophied to be sure, greatly atrophied, but still perfectly normal structure. (Sections under the microscope were shown.) The Professor emphasized that here was a case of eleven years standing, a perfectly translucent kidney, and yet healthy structure, and it was important to save every particle of healthy kidney for your patient, nephrectomy never being justifiable as a primary operation if there be reason to believe there is any healthy kidney structure to be sacrificed. The following case of pyelonephrosis was diagnosed and operated on:

Young man, large tumor of abdomen, prominent on left side, fluctuating and most prominent between crest of ilium and lower border of rib, left side. The diagnosis of nephritic abscess was made and to verify its being a retroperitoneal tumor the hydrogen gas test was made. As the gas filled the colon, which was readily shown

by percussion, the tumor receded or rather the colon covering the tumor, the dullness disappearing and resonance taking its place. This proved that the tumor was retroperitoneal. The patient, being anaesthetized, Professor Senn operated as follows: placing the patient on his right side, with a large round cushion under his right loin; this is important as it gives prominence to the opposite side and widens the space between the crest of the ilium and the last rib. Simons' incision was made and after reaching the tumor, an exploring needle was passed into it and pus withdrawn; the needle being left as a guide, the Paquelin cautery was used to make an opening through the kidney structure, a large amount of pus escaped, the tumor entirely disappearing. A thorough search was made for stone or other foreign body, but nothing was found. After a thorough washing out of the abscess a large double drain was introduced and the wound dressed with iodoform gauze packing, etc.

The Professor emphasized his advice to use large drainage tubes in these cases, so that the cavity of pelvis of the kidney could be seen and its condition noted, this being of great importance as we could then be certain that when the drainage tubes were removed, that the pelvis of the kidney was in an absolutely healthy condition because the parts could be actually seen and their condition noted before such removal. The Professor here also made a special mention of the value of peroxide of hydrogen for cleansing these and all similar abscess cavities and drew attention to its special use in these cases as by it the permeability of the ureter could be demonstrated.

#### CLINIC ON SKIN DISEASES BY PROF. HYDE.

The following cases were presented: A case of tinea sycosis, in which attention was drawn to its superficial resemblance to epithelioma. The next cases shown of tinea favosa, four in number, and they well illustrated the various phases of the disease. The one showing the smooth, shiny, parchment-like membrane of cicatrization and atrophy of a long standing case, the whole of the scalp being in this condition. The patient had received no treatment. The second case showed the same condition on a small patch, the

patient having had treatment, the disease was stopped in its progress.

The other two cases showed the characteristic patches with irregular outline, festooned like, the lustreless dull stubs of hair, the yellowish greenish hue. As to treatment Professor Hyde used corrosive sublimate solution, carbolic acid and iodine, chrysarobine ointment, but would like to add that it will be a tedious cure, which will try the patience of both physician and patient.

The Professor had the group photographed, as it was rare to be able to get together four cases at one time at one clinic.

A case of *psoriasis* was shown with characteristic appearance. The Professor said that the variety we see here in this country is mostly due to the peculiarity of our spring and about the only treatment necessary is to wait for warm weather when the psoriasis will disappear, to return the following spring.

A case of *pityriasis versicolor* was shown, illustrating beautifully this disease.

The last case shown was one of *lupus vulgaris* of the face. The Professor in showing the case drew especial attention to the appearance of the patient, when the face was seen in profile, when as in this case the nose was attacked, in differentiating from syphilitic destruction. In the latter the nose was brought down in the middle, the tip rising, the nose becoming flat, while in lupus the nose, one might say melts away, producing as in this case, the typical parrot-peck expression. The Professor did not believe in the surgical treatment of lupus of the face; the best result he has had from the local injection of creosote.

#### EVENING SESSION.

At the evening session of the society the following cases were reported by the members:

Dr. P. O'Keef, of Oconto, Wisconsin, reported a case of laparotomy for ovarian tumor, attached to the fallopian tubes, size of large orange, cystic. After removing this and examining abdomen found another tumor on the right side, which proved to be a hematocoele. Drainage tubes were used. Temperature never rose above 99°F. She had had a severe attack of pain in abdomen in December and the

September 3, 1892.

*Selected Formulæ.*

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DR. E. J. SMITH reported the following cases:

A case of strangulated hernia of five days' standing.

The strangulation took place on Feb. 18th, the Dr. being called on the 23rd. for the first time. Considering the length of time that had elapsed since the beginning of the strangulation, the Doctor advised an operation at once without attempting reduction.

On reaching the intestine he found the same gangrenous, so that about two inches had to be resected. Circular enterorrhaphy was performed; the continuous Lambert suture was used. Silk was the suture material. The sac was dissected out, no drainage was used. Local anæsthesia by the use of cocaine injection was used. The Doctor in making the injection enters the needle only at one point, pushing it along under the skin its full length, in the direction of the proposed incision, then injecting as the needle is withdrawn, not allowing the needle however to escape from the skin, it is reversed and again pushed its full length under the skin in the opposite direction, and again the injection is made while withdrawing the same. The patients complain of no pain during the operation.

The case made a complete recovery, only two dressings being required. The Doctor then reported a case of operation for gall-stone in which the gall-bladder was opened and 142 gall-stones removed; there had been an attack of peritonitis some time before, and at the time of operation, the peritoneum was adherent to gall-bladder. This case also made a good recovery.

WM. HAUSMANN,  
Secretary.

Elmore, Wis.

#### MALE FERN TOXICITY.

It has been demonstrated by Quirill and Poulsen that oleoresin of male fern may develop its toxic properties when combined with or followed by castor oil, this being due to the solubility of the active constituents in oil, whereby absorption is favored. To avoid accidents, it is hence recommended to employ with this tænicide some cathartic other than castor oil.

#### Selected Formulæ.

The best general pill excipient I ever saw or used is made as follows:

Rx	Powdered slippery elm.....	3 drams.
	Flour.....	1 dram.
	Glycerin.....	2 drams.
	Water.....	4 drams.

Boil until thick paste is formed and be careful not to burn it.

—F. P. Brigham, Jeffersonville, Indiana, in Meyer Brothers' Druggist.

#### SICK HEADACHE.

For a long time I have searched for a prescription that would cure sick headache. Various combinations were tried, but nothing satisfied me until I came across the following in an English work on "Headaches; their Nature, Causes and Treatment," by Wm. Henry Day, M. D. To this I have added one ingredient, the bromide of ammonium. Some may object to the formula on the ground of polypharmacy, but where every drug is given for a definite purpose it is allowable to combine many ingredients into one prescription, especially when the resulting compound is as efficacious as the following:

Rx	Sodii bicarb.,	
	Bismuthi subcarb.,	
	Pulv. acacie.....	3 j.
	Spts. ammon. aromat.....	3 j.
	Ammonii bromidi.....	3 lbs.
	Syr. zingiberi.....	3 lbs.
	Aque dest., q. s.....	3 vols.
M.	Sig.—3 j as required.	

—Ex.

#### ULCERATED CHILBLAINS.

Dr. Brogg (*Internat. klin. Rundschau*, No. 46, 1891) prescribes in ulcerated chilblains the following salve:

Rx	Acid carbolic.....	1 gram.
	Unguent. plumb.....	30 grams.
	Lanolin.....	30 grams.
	Ol. amygdalar. dulc.....	10 grams.
	Ol. lavender.....	gts. xx.

Apply two or three times a day.

#### DIGITALIN IN CARDIAC DYSPNEA.

Rx	Digitalin (crystallized).....	10 grams.
	Glycerin (30° Be.) .....	32 cc.
	Distilled water.....	14 cc.
	Alcohol (96 per cent.) to make .....	100 cc.
	(50 drops of this solution represent 1 milligram of Digitalin.)	

Rx	Digitalin (crystallized).....	0.06 gram.
	Alcohol.....	18 grams.
	Glycerin.....	18 grams.
	(60 drops of this solution represent 1 milligram of Digitalin.)	

### FORMULA FOR THE TREATMENT OF BURNS.

According to *L'Union Médicale* for January 14, 1892, Nikowsky recommends the following treatment in burns:

R	Tannic acid.....	3 drs.
	Alcohol.....	5 drs.
	Sulphuric ether.....	5 drs.

Sig.—Make a solution, and apply locally in cases of burns of the second or third degree. Wash the part with a solution of boric acid, puncture the blisters, and apply by means of a camel's-hair pencil the solution of tannic acid just named. Cover the part with cotton wadding.

### PERMANENT SYRUP OF HYDRIODIC ACID.

R	Iodide of potassium.....	123 grains.
	Tartaric acid.....	112 grains.
	Water.....	1/2 fluid ounce.
	Diluted alcohol.....	1 fluid ounce.
	Syrupy glucose.....	1/4 fluid ounce.
	Syrup.....	enough to make 16 fluid ounces.

Dissolve the iodide of potassium in  $\frac{1}{2}$  fluid ounce of water and the tartaric acid in  $\frac{1}{2}$  fluid ounce of dilute alcohol. Mix the two solutions in a vial, cork and shake it well, and then place it in ice water for about one-half hour; again shake it thoroughly and then pour the mixture upon small white filter, and filter into a bottle containing 1394 fluid ounces of syrup and  $\frac{1}{4}$  fluid ounce of syrupy glucose. When the liquid has run through, wash the vial and filter with  $\frac{1}{4}$  fluid ounce of diluted alcohol, added in several portions. Then add enough syrup to make 16 fluid ounces.

This method is said to afford a clear, transparent and permanent syrup. Glucose is singularly well adapted for the preservation of all syrups of the iodides or bromides, as with its use the reduction of the compound is greatly retarded.—J. W. England.

### ANTISEPTIC TREATMENT OF PROFUSE DIARRHEAS.

Dr. Broughton (*Deutsche med. Wochenschrift*, No. 1, 1892) recommends the following formula:

R	Salicylate of bismuth.....	10 grams.
	Sulpho-carbonate of zinc.....	2 grams.
•	Lime water.....	55 grams.
	Distilled water.....	55 grams.
	Tinct. benzoated opium.....	30 grams.
	A teaspoonful every two hours until the diarrhoea ceases.	

### EUA ANTISEPTIQUE DE PAGLIARI.

The *Bulletin de la société pharmaceutique du Nord*, gives the following formula for Pagliari's antiseptic:

R	Alum.....	100 parts.
	Benzoic acid.....	2 parts.
	Tincture of benzoin.....	10 parts.
	Water.....	988 parts.

Dissolve the alum in the water by the aid of heat, add the benzoic acid, and, finally, the tincture of benzoin. Agitate strongly, let cool, and filter. This makes an excellent toilet antiseptic and can be used as a styptic in mild haemorrhages, etc.

### NEW METHOD OF EXAMINATION OF THE DIGESTIVE ORGANS.

Dr. Sahli, of Berne (*Correspondenz Bl. F. Schweizer Aerzte*; No. 2, 1891), has adopted the following ingenious procedure for determining the condition of the digestive functions: A pill containing about three grains of iodide of potassium is enclosed in a round sheet of very thin gutta-percha paper, the free margins of which are twisted in form of a bag and then fastened by a firm moist cord of fibrine, about one-eighth inch thick. The ends of the cord are brought together by a thread. The rubber sheet should be well covered with talcum, so as to prevent adhesion of the opposed surfaces. To protect the bag during swallowing, it is enclosed in a gelatine capsule. The author's object was to determine the time required for the iodide of potassium reaction to manifest itself in the saliva under various physiological and pathological conditions, this depending upon the rapidity with which the fibrine cord was digested and the iodide set free from its envelope. It has been stated that the manifestation of the iodide of potassium reaction depended upon the quantity of free hydrochloric acid in the stomach, but Sahli's experiments tend to show that the quantity of contained acid exerts less influence than has been thought. In like manner the administration of soda and pancreatic ferments in cases of deficient acid production, for the purpose of initiating intestinal digestion in the stomach, had no effect in accelerating the appearance of the reaction, and sometimes even delayed it. The reason of this was found to be that the acid and pepsin, or the pancreatic ferments, remained for too short a time in the stomach to exert any digestive action, being partly absorbed and partly passed into the intestines.

The value of this method in demonstrating the condition of the digestive functions is shown by some experiments made by Dr. Henne regarding the influence of pepper on stomach digestion. He found by chemical examination of the gastric juice that pepper administered in doses of  $2\frac{1}{2}$  grammes before meals had no essential effect upon the gastric functions, but that the iodide reaction appeared earlier if no pepper was given. Owing to the laxative effects of pepper, as demonstrated by these experiments, it is probable that it exerts a favorable effect upon intestinal digestion.

September 3, 1892.

*Editorial.*

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## THE

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## Leading Articles.

THE TREATMENT OF ULCERS OF  
THE LEG.

The therapeutics of ulcers and varicose veins of the lower extremities may fittingly be considered together, because in hospital practice, at least, a very large proportion of leg ulcers are directly or indirectly due to over distension of the veins of the part.

Although this affection is a very common one, it is a fact that too often its treatment lacks the care and precision with which other surgical procedures are carried out. Of all the various forms of leg ulcers the varicose ulcer is certainly the most chronic as well as the most common. Since the pathology of these ulcers has been better understood, together with the conditions necessary for their reparation, more rational treatment has undoubtedly been pursued by the great mass of the profession. The importance of rest, position and pressure has been generally realized, and the means by which these ends have been sought particularly comprise nearly all of the modern modes of treating them.

While certain modifications of treatment are almost universally advised in the different varieties of leg ulcers, in general terms the condition of the ulcer itself is the only practical guide to a rational, local therapeusis. Consequently, it matters little regarding local treatment whether an ulcer belongs to one or another of the classes ordinarily seen, viz: simple, varicose, syphilitic, tubercular, epitheliomatous, traumatic, etc.

The diagnosis of leg ulcers usually is a very simple mental process. Sometimes, however, it is very difficult to decide as to the real nature of certain forms of ulceration. In doubtful cases which have resisted thoroughly applied local and general measures it is always wise to call in consultation a well-qualified specialist upon skin diseases, and often it will be found that some important aetiological factor has

been overlooked, or that the specialist will distinguish the obscure and intractable lesion as belonging to a class in which amputation may be the only resort, viz: in bad cases of malignant ulceration. In this connection it should be borne in mind that long standing cases of simple ulceration may rapidly become malignant.

At a recent meeting of the Philadelphia County Med. Society, Dr. Thomas S. K. Morton read a very interesting paper upon the treatment of leg ulcers, in which he claimed many advantages for the mode of treatment pursued by him at the Philadelphia Polyclinic. His results have been so good that it will be of value to note his method. This consists in washing the ulcerated area thoroughly with soap and water, then with 1:1000 bichloride solution; the surrounding parts are shaved if this seems necessary to secure cleanliness. If no septic conditions are present in or around the ulcer the bichloride is omitted. Next, the ulcer and one inch of the surrounding healthy skin are covered by overlapping half inch strips of "Lister protective," over which moist bichloride gauze is evenly placed and the dressing completed by a bandage. The bandage is perhaps the most important part of this treatment, and consists of figure-of-eight turns around the calf, without reverses—the precaution in applying it being to keep the two edges of the bandage equally tense. Dr. Morton has used this bandage for the past five years, and he states that it will not only remain just as applied for days or even weeks and be absolutely comfortable to the wearer, but also permits the employment of the fixed antiseptic dressing while patients pursue their usual occupations almost unconscious that their former disabling disease is still present. This dressing is reapplied every day until the parts become odorless, free from all irritation and aseptic. Subsequently it is renewed every second day if the patient is actively working. By this simple form of

treatment assisted by the application of silver nitrate solutions, scarification, occasionally skin grafting and applications of pepsin to large sloughs when these measures seem indicated, Dr. Morton claims that the time required to heal is usually incredibly short.

The method of treating this class of ulcers which has just been detailed can be employed with great advantage among the poorer classes, and its adaptability for such cases is at once apparent.

When varicose veins constitute the active cause of the ulceration, it becomes a question of how the vessels can best be supported. A firm, even bandage is after all the supporter *par excellence* and is usually effective in all mild or moderately severe cases. Where, however, the varices involve the greater portion of the limb, excision of the enlarged veins is the best remedy for the ulcers present. A very good remedy for varicose veins, according to Morton, is an ointment of ichthylol and lanoline (1:4) spread upon lint and applied to the limb by the same bandage which he ordinarily employs in dressing.

#### SYPHILIS OF THE PHARYNGEAL AND PRE-EPIGLOTTIC TONSILS

Drs. Moure and Raulin. (*Rev. de Larynx. Ot. et Rhin.*, No. 6-7, 1891.) make a contribution to the study of the manifestations of syphilis upon what have been described as the third and fourth tonsils, or in other words in the adenoid tissue in the vault of nasopharynx and in the follicles of the buccal pharynx at the base of the tongue.

The lesions, it would appear, are identical with those which occur upon tonsils proper, but their study has been neglected. When present they may cause modifications in deglutition, phonation and respiration, and may point to the seat of trouble in ear complications where nothing is taught by a superficial examination of the back of the mouth and throat. Dr. Ladd thinks the abuse of alcohol and of tobacco influences not only the development of these lesions but their duration.

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## Book Reviews.

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## Book Reviews.

## THE SCIENCE AND ART OF MIDWIFERY.

By William Thompson Lusk, A. M., M. D.  
Professor of Obstetrics and Diseases of Women  
and Children in the Bellevue Hospital Medical  
College Fourth edition, revised and enlarged.  
New York: D. Appleton & Co., 1891.

The rapid strides of progress in midwifery and gynaecology are nowhere better illustrated than by a casual glance at the successive editions of the text-books on these subjects. The greatest advances will be noticed to have occurred in those directions in which modern surgery has cleared away many formerly insurmountable obstacles from the pathway of the practitioner in these branches.

In comparing the present edition of this work with its predecessor, we observe such vital differences, according to our modern thoughts, that for all intents and purposes the book before us is almost wholly new, only retaining the literary style and arrangement to mark its relationship to the volume of a few years ago. The development which has occurred in the theory and practise of midwifery has been due to the pains-taking efforts which have more recently been in vogue to reduce our knowledge of the anatomy and pathology of the pelvis and its organs to exactness of expression and record. The studies in the normal and pathological anatomy of the pelvis have largely contributed to modify the theories and accepted mechanism of labor. The revelations concerning antiseptics and asepsis have largely modified and restricted many of the formerly very common diseases following labor, and their application to surgical practise has made it possible to obtain results which the most sanguine observer of but seven years ago could have conceived scarcely.

From what has been said it will be apparent that it is impossible in our limited space to minutely compare the author's present volume with the edition of 1885. The changes in theory and practice have so radically destroyed many deductions of that period that comparison is impossible.

Many portions of the work have been entirely rewritten. No effort has been spared apparently to present the best obstetrical teachings of the day. The chapters on the mechanism of labor have been most carefully revised. The chapter

upon diseases of the decidua is well worth reading. Extra-uterine pregnancy is excellently presented, and the treatment is wholly in accord with the advances which have been made in surgery. Abdominal palpation and pelvimetry receive careful consideration. The instruments used in the latter are carefully described. The subject of puerperal fever is presented with the modern views and compared with former ones. The same may be said of eclampsia. The last chapter of the work contains a well-written, short description of puerperal insanity. The author states that fully sixty per cent. of cases end in recovery. This estimate is lower than that of Bevin Lewis, who has quite recently written a masterly treatise upon diseases of the mind. In the space allotted to puerperal fever there are five very well executed colored prints of microscopic sections of puerperal endometritis, which show plainly streptococci pyogenes, staphylococci aurei, and other forms of disease germs.

The book is very creditably printed and bound, contains 761 pages, 32 chapters, and is illustrated by 232 illustrations and 4 handsomely engraved plates taken from nature. It is a very complete treatise for student or practitioner, and we can unhesitatingly say that it leaves very little to be desired as a modern reference book. The index in by no means an insignificant feature, and adds greatly to its usefulness.

## CHANGES IN THE CEREBELLUM AS THE RESULT OF CEREBRAL HYDRO-CEPHALUS.

Chiari differentiates three types, which are illustrated by exhaustive clinical histories and pathological descriptions, too long for reproduction. As the first type, he describes a drawing out of the cerebellar tonsils and the median part of the inferior lobes into processes which accompany the medulla into the cervical canal. The second type includes the dislocation of parts of the cerebellum into the dilated fourth ventricle, which is prolonged into the expanded cervical canal. As an instance of the third and severest type he relates a case, supposed to be of hydromyelocele cervicalis, in which the sac and contents were removed. Autopsy showed that almost the entire cerebellum, expanded into a cyst, had been removed.—*Deutsche Med. Wochenschr.*, No. 42, 1891.

**Periscope.****THERAPEUTICS.****TEUCRIUM SCORDIUM IN PRURITUS ANI.**

Dr. Brinton (*Wiener med. Presse*, No. 17, 1892) recommends the use of teucrium scordium in pruritus ani. In obstinate pruritus ani from haemorrhoids or when there is no local lesion, he employs the powdered leaves with success, in doses of five to six decigrams (eight to ten grains) three times a day, half an hour before meals. After they have been used for seven to ten days the pruritus gradually disappears entirely. When the haemorrhoids are well developed the results are not so good; from this it is seen that the remedy acts chiefly upon the nervous cause of the pruritus.

**THE TREATMENT OF TETANUS.**

Rènon (*Ann. de l' Inst. Pasteur*, April, 1892) reports two cases of tetanus treated by the method of Behring and Kitasato. Although both terminated fatally, they afforded some useful indications, particularly regarding the dose of serum which should be employed. Behring and Kitasato discovered that the serum of the blood of animals immunized against tetanus exerted a powerful antitoxic action upon the tetanic poison; they showed that susceptible animals resisted the inoculation of quantities of tetanus cultures several hundred times greater than the lethal dose if the animals were injected at the same time, or some time after, with a little of the blood serum of an artificially immunized animal. Rènon compares his two cases with four recorded by Tizzoni, all of which were successful, and with one of Baginsky and Kitasato which was unsuccessful. In Rènon's own cases the duration of the disease was, in one seven, and in the other, eight, days; in the case of Baginsky and Kitasato the duration was eight days. On the other hand, in two of Tizzoni's successful cases the treatment was only commenced about twelve days after the onset of the disease. From these facts Rènon is inclined to believe that Tizzoni's results were in some degree due to the fact that his cases were of a milder type and of slower progress. He does not consider that the want of success in these cases affords any valid objection to the applica-

tion of the treatment to cases of tetanus in man; but he points out that it should be commenced as soon as possible, and that possibly larger doses of the serum may be required. He observed no ill-effects from the treatment; on the contrary, each injection was followed by marked, but unfortunately, only temporary relief.—*Brit. Med. Jour.*

**ARISTOL IN CHRONIC DYSENTERY.**

Dr. Randall (*Med. Neuigkeiten*, No. 17, 1892) has treated three cases of chronic dysentery with aristol with excellent results. The most serious case was that of a sixty-year-old man, who had for six months suffered from chronic diarrhoea, and for the last six weeks had been obliged to keep his bed. The localization of the pains pointed to the lower portion of the transverse colon being involved in the ulcerating process. A suppository of two and a half grains of aristol and one-third of a grain of morphine was ordered to be inserted three times a day. Two days later the stools became less tepid, more consistent and free from blood. Within a week the painfulness disappeared, and only one more haemorrhage appeared. The stools, which had been very painful and of hourly occurrence, were reduced to six or eight per diem; they were soft, but not thin, and nearly free from epithelial debris. In ten or twelve days all traces of rectal ulceration had disappeared. Then only one grain was given per diem, and morphine in the evening. In a short time he was on the road to recovery.

**ERGOTININE.**

In *La Médecine Hypodermique* 1892, No. 2, p. 17, Dr. Franck recommends the use of this active principle of ergot in place of ergotine, which is frequently inert and often untrustworthy. It is prompt, surer, and more constant, does not give rise to local accidents, and is useful in smaller dose— $\frac{1}{16}$  to  $\frac{1}{8}$  of a grain. Nor, indeed are these injections painful. Evertky and Denslow have used it in acne. Alternating with hypodermatic injections of iron, it is useful in the menstrual disturbances of young girls. It has been used with good results in several cases of cerebral apoplexy, epistaxis, haemoptysis, haematuria, haematemesis, and purpura.

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haemorrhagica. Haning has used it in suppository in haemorrhoids, and it is valuable used hypodermatically in this same condition when injected into the margin of the anus. Dujardin-Beaumetz has treated with success menorrhagias, Ducros has employed it for paralysis, and Payan for paraplegias. In lead-paralysis Hiter has obtained a cure in less than a month, giving also iodide of potassium. Payan, Allier, and Guersant, Jr., have treated paralysis of rectum and bladder, especially in old subjects, by this remedy.—*Amer. Jour. Med. Sci.*

#### RESORCIN IN GASTRIC ULCERS.

Pope uses resorcin in a dose of five grains three times a day in cases of gastric ulcer. It is both antiseptic, analgesic and haemostatic. Its analgesic property being the most valuable, enabling the stomach to tolerate food. He has also given it with advantage in gastric cancer.

#### TREATMENT OF APPENDICITIS.

At a meeting of the Paris Surgical Society on May 25th, 1892 (*Sem. Méd.*, June 1st, 1892) Jalaguier showed two cases of appendicitis which had been cured by operation. The first was a strong boy, aged 14½, who had had the vermiciform appendix removed on account of recurrent attacks of appendicitis. The second was a child, aged 10½, who, after two previous slight attacks of appendicitis, was admitted on March 24th, 1892, to the Hospital Trousseau, presenting the following symptoms, namely, abdomen very tender, especially in the left iliac fossa, considerable distension, frequent vomiting, and pinched expression of face. The temperature was 38.5° C., the pulse 120. A median laparotomy was at once done, and the peritoneal cavity opened. The intestines were seen to be covered with a layer of fibrous lymph, and to be bathed in pus. Collections of pus were also found in the iliac fossa, in the pelvis, and between the omentum and coils of intestine. A considerable collection of pus was also found behind the cecum; the pus in this part had a fetid odor, and on washing out the cecal region a ball of feces as large as a pea and of the consistence of mastic was removed. The

abdomen was then thoroughly washed out with boric solution, and five large tubes inserted for drainage; two were placed in the pelvis, two behind the cæcum, and one in the left iliac fossa. Several strips of salol gauze were also packed over the intestinal coils. The upper three-fourths of the wound were closed with sutures, and a dressing of salol gauze applied. The child bore the operation, which lasted twenty-nine minutes, well; vomiting did not occur, and the bowels were open during the night. Recovery soon took place; the strips of gauze were removed on the sixth day, the drainage tubes reduced to one on the tenth day and discontinued on the fifteenth day. On May 14th the child was discharged well.—*Brit. Med. Jour.*

#### PIPERAZINE.

Drs. Biesenthal and Schmidt review, in the *Berliner Klinische Wochenschrift*, January 11, 1892, the clinical reports on piperazine which have appeared recently. The reports of Vogt, Ebstein, Heuback, Krakauer, and Brik (see *Therapeutic Gazette*, February, 1892, p. 114) are all very favorable. Testimony seems to be nearly unanimous that the remedy is harmless and that it is effective as a solvent of uric acid.

Biesenthal and Schmidt report seven cases in which the remedy has been tried. Four of the cases are given in detail. In three of the latter, who were gouty patients, and had attacks of gout, marked relief was obtained. The fourth patient had violent attacks of renal colic. On the first day the piperazine was used, an extraordinary quantity of gravel was passed. After the second dose, on the next day, large quantities of gravel were passed several times, and almost immediate relief was experienced. Similar results were obtained in other cases. Biesenthal and Schmidt recommend the remedy very highly.

Internally, they say, piperazine is best given in dilute solution in doses of fifteen grains distributed during the day. Its taste is very slight. As it is not irritating to mucous membranes, a one or two per cent. solution may be employed in washing out the bladder in the case of vesical calculi. Hypodermic injections into gouty deposits and local applications to gouty swellings may also be employed.

## THE TREATMENT OF INEBRIETY.

Dr. Charles L. Dana has made a very careful study of 614 male alcoholics treated at Bellevue Hospital. He believes that strychnine has a certain degree of specific effect in inebriety, and in alcoholic intoxication. In acute alcoholism, when the system is overwhelmed with the poison, one-sixtieth of a grain every two or three hours; in the chronic form, it should be administered in good doses for a considerable time. In ordinary acute delirium of alcoholism, twenty to forty grains of chloral, repeated in smaller doses in two or three hours, and combined with digitalis and strychnine, is the safest and surest means of controlling the excitement and securing sleep. A preliminary laxative, and a careful diet of hot milk and beef-tea with red pepper, should be insisted upon. In febrile delirium tremens, depressants must be used with care; cold baths or cold wet-packs, with friction, must be applied every two or three hours while the temperature remains high. Hypodermic injections of morphine are rarely needed, and he does not advise them.—*New York Medical Record*, 1892, No. 1115, p. 309.

## PUMPKIN SEED IN THE TREATMENT OF TAPEWORM.

Dr. H. Roemer (*Pharmaceutische Presse*, No. 15, 1892), recommends the peeled seeds of the common pumpkin as an effective and safely acting taeniafuge. For an adult the dose may be placed at sixty or seventy grammes (two to two and a half ounces) of the peeled seeds. Half the quantity of oilless cocoa is added, with a little sugar and some syrup, and water enough to make a plastic mass on rubbing it in a mortar. This is made into fifteen or twenty pastiles and coated with sugar. The patient, after the usual preliminary period of fasting and a dose of castor oil, is given one of the pastiles every ten minutes. Children require but half this quantity. The result is astonishingly good. The writer has expelled over one hundred tapeworms in this manner. Only in a few cases was vomiting noticed. In general, the patient feels no disagreeable symptoms.

The seeds of the last year should be used and carefully peeled, which will be found a tedious task. Whether the oil is the ac-

tive principle, or whether it is first developed by the crushing of the seed with water, as is the case with bitter almonds, mustard, etc., the writer does not attempt to solve.

## TRICHLORIDE OF IODINE IN OPHTHALMOLOGICAL PRACTICE.

At the Ophthalmological Congress recently held in Paris, Pflüger (*Sem. Med.*, May 4th, 1892) spoke strongly in favor of trichlorine of iodine as an antiseptic in various affections of the eye. He recommends a 1 in 5,000 solution for ordinary cases, and solutions of 1 in 2,000 or 1 in 1,000 when an energetic antiseptic is required, as in infectious lesions of the eye, whether superficial or deep. In commencing panophthalmitis, he uses a 1 in 1,000 solution.

## THE TECHNIQUE OF INTERSTITIAL IODINE INJECTIONS IN THE TREATMENT OF GOITRE.

Dr. Duguet has used this method since 1874 (*Journal de Médecine*, 1892, 4e cahier, p. 129). He concludes that the recent fleshy goitres, occurring ordinarily in young subjects, are the ones which disappear most easily and rapidly; the recent cystic goitres are still more rapidly cured; the goitres of long standing—in general, hard, fibrous, calcareous, sometimes aneurismal—result often very favorably, at other times less satisfactorily. The solution used is one part of iodine to twelve of 90° alcohol, injected with a hard-rubber Pravaz syringe carrying a steel needle, the latter to be cleansed after each time of using with a weak solution of ammonia. In the intervals the syringes and needles are kept in a ten per cent. solution of carbolized oil. The injection is made deeply into the tumor, but only when, after making the puncture, blood does not flow during the ensuing several seconds. The injection is made slowly, watching the patient's face. For checking the cough which may be produced by the injection, after taking out the needle, the patient takes several swallows of wine. These injections are repeated at intervals of eight or fifteen days, but not during menstruation, nor in patients who suffer from albuminuria. The amount injected is seven to fifteen drops.—*Amer. Jour. Med. Sci.*

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### STROPHANTHUS IN EXOPHTHALMIC GOITRE.

Dr. Fergusson (*Medical Standard*) claims good results from strophanthus in exophthalmic goitre. In nine cases the almost immediate disappearance of cardiac symptoms permitted patients to resume their occupations. The pulse fell from 150 and over to between 85 and 75, and there was a diminution in the exophthalmia, and in the thyroid gland to a fibrous condition, the result of the great duration of the disorder. Fergusson recommends eight to ten drops of the tincture thrice daily. In some cases he has given as much as twenty to twenty-five drops as a dose. Small doses have no effect whatever.

### MIGRAINE.

This was the subject of a clinical lecture by Dr. G. M. Hammond. Migraine usually first makes its appearance at about the age of puberty, though it may develop earlier. Anglo-spastic migraine is supposed to be due to a spasm of the blood-vessels on the affected side as a result of irritation of the cervical sympathetic. Whether the vascular spasm is a simple accompaniment of the disease, or its approximate cause, has not yet been determined, but in the author's experience remedies which dilate the blood-vessels give relief, while those which contract the blood-vessels increase the pain. In treating this form, inhalations of nitrite of amyl and internal administration of glonoin in doses of 1-100 of a grain, alcohol in moderate quantities, quinine in doses of from 10 to 15 grains, or a hypodermic injection of  $\frac{1}{10}$  or  $\frac{1}{20}$  of a grain of strychnine, will usually stop the paroxysm. The author does not administer opium for this disease, owing to the liability of the habit being formed. In the general treatment for the disease sources of irritation should be removed; eye defects removed; constipation or indigestion should be removed, or any other condition that may be a contributory cause. Fowler's solution in five or six drop doses three times a day for several months is considered a favorable remedy. Iron, quinine, strychnine and the phosphates are also recommended. Another form of migraine is the angio-paralytic form. In this form the vascular condition is that of dilatation.

For this the author recommends phenacetin in large doses, arsenic and the bromides.—*International Clinics*, Jan. 1892.

### MEDICINE.

#### A CASE OF PROGRESSIVE GENERAL PARALYSIS OF VERY EARLY COMMENCEMENT.

Charcot and Dutil (*Archives de Neurologie*, March, 1892) state that the symptoms appeared at the unusually early age of 14, and the further development of the affection leaves practically no doubt as to the correctness of the diagnosis. All the essential symptoms were present, profound impairment of the intelligence, speech embarrassment, pupillary inequality with the Argyle-Robertson sign, trembling of the hands, congestive seizures and attacks of sensory epilepsy. This precocious or *juvenile* variety presents, the writers think, some peculiarities which distinguish it from the ordinary or normal type. Occurring most often at the critical period of puberty (14 to 16), psychical troubles are the first to appear, and one of the most marked features is an arrest of physical development. The mental condition is in the majority of cases one of tranquil debility, without excitement or ambitious delirium, and much resembles that occurring in the general paralysis of women. Its duration varies from two to five years. The chief factors in the aetiology are hereditary neuropathic predisposition and congenital syphilis.

### RHEUMATOID ARTHRITIS.

Blake (*Provincial Medical Journal*, 1892, xi, 121, p. 11) expresses the view that a proportion of cases of rheumatoid arthritis are dependent upon some form of intoxication, in consequence of which the nervous system suffers secondarily. He therefore recommends that in a given case a careful search should be made for a source of poisoning from within or without. This found and removed, the circulation is to be supported, mental strain relieved, and nutrition maintained. Passive, motion and massage, conjoined with electricity, should be energetically employed.

## MINERS' NYSTAGMUS.

While this is a subject in which our special interest is almost purely a scientific one, it is worth while to note in a few words a review in the *Oph. Rev.*, April, 1892, of a recently published monograph on the subject by Simeon Snell. After a careful study of the conditions under which the miners work, and the details of numerous cases of miners' nystagmus, he very positively attributes the affection to the excessive action of the ocular muscles demanded by the constrained position in which the miner works. While not denying some influence to insufficient illumination, he considers it as a factor of subordinate importance. He does not believe it due to central changes. These views are somewhat at variance with those of other competent observers, especially as regards the importance of illumination. Miners' nystagmus would seem to be due to a "continued effort to fix under conditions which render continued fixation, peculiarly difficult," and the importance of each factor must be determined in each case. Sometimes a change simply in the manner of work, and not in its nature, is sufficient to give relief to this distressing condition, and the volume in question gives many valuable points as to prevention and treatment.

## INFECTIVE ENTERITIS.

Gaffky (*Deut. Med. Woch.*, April 7th, 1892) reports the cases of two laboratory assistants and their servant who were seized on the same day with an acute illness. The chief symptoms were sudden onset with shivering, fever, diarrhoea, delirium, and prostration. In one case there was also albuminuria, and in another haemorrhages into the mucous membrane of the mouth. In the third case the disease was mild. The poison had evidently entered by the mouth. Some milk was the only common article of diet of which these patients had partaken on the previous day, and which had been brought into the laboratory. The author had been making experiments with the bacilli found in cases of meat and sausage poisoning, but he does not think the milk could have been infected in this way, as it had only been in the laboratory a short time. It was found out that in the dairy from which this milk was obtained one of the cows had suffered from diarrhoea, small

blood clots being passed. The dejecta, examined with all precautions by Professor Winckler, showed a very small and active bacillus. The same micro-organism was found by the author in the patients' stools. In cultivation and inoculation experiments it behaved somewhat differently from the micro-organism of meat poisoning. The author thinks that it was a culture of the bacterium coli commune of exceptional virulence and rapid growth, but he adds that much caution is needed in such conclusions, because the constant presence of this bacterium, pathogenic to many animals, makes it difficult to recognize other possible causes of disease in the intestinal contents. A specimen of the milk examined showed only micrococci innocuous to guinea-pigs. But the poison might have got into the milk otherwise than by the way of the mammary gland itself, that is, by the contamination of the milk by the dejecta, and the author says that this fact is not sufficiently recognized in the transmission of infective disease, even such as tubercle, to man. The boiling of milk is still insufficiently adopted.—*Brit. Med. Jour.*

## EXOPHTHALMIC GOITRE.

Möbius, in an exhaustive article on this disease, draws the following conclusions: Basedow's disease is probably due to changes in the function of the thyroid gland. To prove this he mentions: (1) The similarity between this disease and others which depend upon changes in the thyroid, namely, myxoedema and cretinism. (2) The fact that in some cases exophthalmic goitre is secondary to simple enlargement of the thyroid. (3) That operative treatment seems in some cases to either benefit or cure the disease.

We know little or nothing about the causes which bring on the primary changes in the thyroid gland. It is probable, however, that the action of some poison on the system is an important aetiological factor. Among predisposing causes are the female sex, neurotic inheritance, possibly climatic conditions and national peculiarities. Under favorable circumstances those conditions which diminish the resistance of the body, more especially of the nervous system, seem to act as exciting causes.—*Deutsche Zeitschrift f. Nervenheilkunde*, Nov., 1891.

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### THE EFFECTS OF INFLUENZA UPON THE MIDDLE EAR.

Sir William Dalby, in a clinical note published in the *Lancet* of 20th of February, stated that a person with healthy ears has little to dread from influenza so far as the mucous membrane of the middle ear is concerned, but that it may become a serious trouble to one whose ears have formerly been the seat of inflammation. A correspondence on the subject will be found in subsequent numbers of the *Lancet*, in which the various writers agreed with the latter portion of Sir William's statement, but took exception to the first part. Each, from his experience of cases of middle ear inflammation following influenza in those who previously had perfectly healthy ears, took exception to the conclusion that "those with healthy ears had little to dread."

### THE PATHOLOGY OF PARALYSIS AGITANS.

Borgherini (*Revist. sper. di Freniatria e Med. leg.*, 1891, vol. xvii, fasc. 1, 2) has reported a case of paralysis agitans, in which after death, on careful microscopic examination, an excessive formation of connective tissue was found in various parts of the cerebro-spinal nervous system, with pigmentation and atrophy of gray matter and ganglion cells. The walls of the capillaries were thickened, the lumen of the vessels was increased, and the perivascular lymph spaces were dilated. In many places miliary aneurisms were present. The lesions are thus those of senile involution.—*La Médecine Moderne*, 1891, No. 43, p. 746.

### HIP-JOINT DISEASE AND SOME NEW LATERAL TRACTION SPLINTS FOR ITS TREATMENT.

Phelps, (*Med. News*, 1891, lix., 725.) writes:—To conclude, my observations lead me to believe that one of the most serious elements of destruction in hip-joint disease is the trauma and pressure produced by muscular spasm; that fixation of the joint without extensions is an impossibility; that the successful treatment of the joint must depend upon its absolute immobilization, which can only be produced by proper extension and fixation; that the constitutional treatment of hip-joint disease amounts to but little,

independently of mechanical treatment; that mechanics is everything; that extension in the line of the axis of the shaft and in the time of deformity alone in hip-joint disease is entirely wrong; that extension should be made in a line parallel to the axis of the neck, in other words, two lines of extension; that ankylosis is not produced by immobilization, but by the severity and character of the inflammation; that the long traction hip-splints in general use neither properly extend nor immobilize the joint; that in a large percentage of cases the intra-articular pressure results in the destruction of the joint or in ankylosis; that the results in hip-joint disease should be as good as those in knee-joint disease and will be, provided perfect immobilization can be maintained; that patient should never be allowed to step upon any positive apparatus; that a high shoe in the well leg, and crutch, should be insisted upon until the patient is cured; finally, that the angular deformity seen in cured cases should not occur—such cases are a standing rebuke to the splint and methods employed.

### TABES DORSALIS.

In a recent lecture at the Salpetrière, P. Blocq (*Gaz. Hebdomadaire de Med. et de Chir.* March, 1892) stated that recent researches upon the morbid histology of tabes in its first stage show that the internal radicular fasciculus is invariably the primary seat of the pathological change. The fibres of this system are thick, develop at a period of fetal life anterior to the seventh or eighth month, and are the conducting paths of the muscular sense. The other fibers of the posterior root—slender and not apparent until the foetus is near maturity—are the media by which cutaneous impressions are transmitted. From an evolutionary standpoint the muscular sense is inferior to the cutaneous sensibility its subservient neural elements consequently are the more prone to the influence of hereditary defect. This latter, he further considers, is the main aetiological factor in tabes, though often an accidental exciting agent, such as syphilis, can be discovered. In Friedrich's disease the heredity alone determines the occurrence of a lesion which at first is identical in situation and nature with that of early tabes.—*Brit. Med. Jour.*

THE ROUTE OF RESPIRED AIR  
THROUGH THE NOSE.

Kayser (*Arch. of Otol.*, xx, 1) asserts that during inspiration in the normal nose the bulk of the air passes along the septum, above the inferior turbinated bone, describing a semicircle in its course, and extending upward nearly to the roof of the nose. The general opinion that the current of air passes through the *pars respiratoria* is erroneous. The division of the cavity of the nose into a *pars respiratoria* and a *pars olfactaria* is permissible anatomically, but not justifiable physiologically.

DIAPHRAGMATIC HERNIA.

Niemöller (*Berl. klin. Woch.*, April 11th, 1892) relates the following characteristic case. A man, aged 25, had complained for six months previous to admission of nausea, vomiting, and loss of strength. He was thought to be suffering from chronic gastric catarrh of alcoholic origin, and dilatation of the stomach. A swelling of doubtful nature, but thought to be possibly a misplaced organ, was felt in the umbilical region. In three months' time the patient died. At the necropsy a tumor was found in the thorax immediately above the diaphragm and to the left side, of the size of a man's fist. It communicated with the stomach, for pressure on the latter caused it to swell. By pulling on the stomach, the protrusion could not be reduced, owing to the adhesions. The communication was through the tendinous part of the diaphragm. The much dilated stomach was covered in great part in front by the gastro-splenic ligament, and the colon also crossed it. The pylorus instead of lying to the right of and below the cardia, lay to the left above. The part of the stomach near the pylorus formed the hernia. The spleen was displaced backwards, and there were many peritoneal adhesions. After referring to the fact that the condition is mostly made out only after death, the author draws attention to the percussion note over that side of the chest. He says that the normal percussion note is replaced by a tympanic one, and that the height to which this latter extends depends on the gaseous contents of the stomach or intestine. Treatment can mostly only be symptomatic. These herniae are divided into the congenital and traumatic. In the above case

the increased abdominal pressure brought about by the vomiting forced the viscera through the defect in the diaphragm. The displacement of the organs, and especially that of the pylorus, unless due to peritoneal adhesions, was difficult to explain.—*Brit. Med. Jour.*

GLYCOSURIC, OR TRUE TABES.

Drs. Guinon and Souques, (*Archives de Neurologie*, March, 1892), state that in a glycosuric case if the nervous symptoms be limited to loss of the reflexes, fulgurant pains and loss of objective sensation, true tabes may be suspected, but is not demonstrated beyond doubt. Results of antiglycosuric treatment may aid, but not render certain, the diagnosis, since Westphal's symptom in diabetic cases is the last to yield to treatment. If it yield to treatment the presumption is in favor of diabetic pseudo-tabes. If glycosuria result in an ataxic case, then the absence of polyuria, variability of the amount of sugar, and absence of polyphagia and polydipsia, are in favor of a tabetic origin, especially if anaesthesia, frequent pulse and laryngeal crisis be present. If these last symptoms be absent the chances are in favor of diabetes, especially if the usual symptoms of diabetes be present. Diabetes may, however, complicate locomotor ataxia.

TUBERCULOSIS OF THE IRIS.

For some reason not easy to explain the iris is sometimes the seat of a local tuberculous process, the recognition of which is a triumph of diagnostic art. As to the identity of the lesion, there is no room for doubt, and it is highly important to decide how the bacilli got there and what is the prognosis. Hitherto tuberculosis of the iris has been generally regarded as a form of local tuberculosis, and the eye is consequently removed to prevent constitutional infection. This is a grave proceeding, and acquires additional gravity from the arguments advanced by Prof. Leber in support of the iritic affection being only a secondary, and not, as usually supposed, a primary lesion. He points out that the bacilla can only reach such a structure as the iris by one channel, viz., the blood, and the presence of the bacilla in the blood implies the existence of a focus of infection elsewhere in the body, in the glands,

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the lungs, etc. Obviously if this be the case, enucleation of the diseased eye would not be justifiable on constitutional grounds. On the other hand, some few cases have been recorded of recovery after removal without any subsequent tuberculous manifestation. This fact may be interpreted in two ways—either as an argument in favor of the "local" view or as a reason for doubting the validity of the diagnosis. The latter repose exclusively on the bacteriological examination of the diseased tissue, and it must be confessed that the alleged discovery of "one or two characteristic bacilli" hardly carries conviction. Pending further knowledge on this subject, it is to be hoped that no one will remove eyes on the ground of tuberculosis of the iris unless and until its functional integrity has been hopelessly compromised.

—*Med. Press.*

#### PARALYSIS AGITANS IN A YOUNG MAN.

Quintard (*Bull. de la Soc. de Med. d'Angers*) has reported the case of a youth, sixteen years old, who presented the symptoms of paralysis agitans. Two years previously, following exposure to cold, tremor appeared in the right hand and continued for a month; while within two months the tremor had reappeared, now extending to the arm and shoulder. Soon the characteristic movements also involved the lower extremity upon the same side.—*Journ. de Méd. et de Chir. Prat.*, 1892, lxiii, 5, p. 182.

#### SURGERY.

##### ON RESECTION OF THE LIVER, ESPECIALLY FOR HEPATIC TUMORS.

Keen (*Boston Medical and Surgical Journal*, April 28, 1892) gives the results of analysis of twenty cases of resection of the liver.

The ages of these cases varied from 21 to 58 years. In striking contrast to age, sex is evidently a potential factor. Of the nineteen cases in which this was given, sixteen were females. The author thinks this frequency has probably something to do with tight-lacing.

The tumors and portions of liver removed have varied in size from a small nut to three fists. Of the twenty cases nearly all were incorrectly diagnosed. In some few cases floating kidney was diagnosed, while in others tumor of the pan-

creas was supposed to exist. The tumors found were echinococcus and hydatid cysts, cancer, syphilis, sarcoma, and adenoma.

The author thinks, as a result of experiments on animals, a large portion of the liver can be removed without interfering with its function and without any unreasonable danger.

Ponfick found that even the removal of three-fourth of the liver could be recovered from, although the prostration was very severe at first. Von Meister relates that when the above amount is removed, within a space of thirty-six days, repair had advanced to such an extent that the original weight of the organ was regained.

The escape of bile in the peritoneal cavity is generally of no consequence.

In preventing hemorrhage the base of the tumor is severed by repeated small touches of the cautery point, the large vessels all being ligated. The stump, in the majority of cases was returned to the abdominal cavity; while in six cases it was sutured in the abdominal wound.

Of the twenty cases seventeen recovered, two died and in one the result was unknown. The mortality thus far has only been ten per cent.—*Univ. Med. Mag.*

##### CONTRIBUTION TO THE TREATMENT OF EPIDIDYMITS WITHOUT RESTRICTION OF EXERCISE, WITH A SKETCH OF A SIMPLE BANDAGE.

Philippson (*Theurapeutische Monatshefte*, April, 1892,) describes a new treatment of epididymitis which allows the patient perfect freedom to go about. The principles of his treatment are:

(1) Compression of the testicle, which causes the inflammatory swelling rapidly to disappear.

(2) Puncture of the tunica vaginalis. Sometimes compression alone is indicated, while in other cases puncture and compression may be necessary.

As a dressing iodide of lead plaster was first tried, but this had the disadvantage of producing excoriations. He then used suspensors. It was found difficult to get two alike, and they were rather difficult to adjust. One of two methods of compression, by means of bandages, may be used:

(1) Two flannel bandages, quite elastic, and two circles,—one of flannel, the other

of gutta-percha. One bandage first draws down the testicle from the inguinal canal. The two circles are then placed underneath the testicle and covered by succeeding turns.

This method often produces unbearable pain.

The author recommends the following:

(2) A flannel bandage, three metres long and three centimetres wide is used, the first turn being applied above the testicle. This end of the bandage he allows the patient to hold until the following circular turns are firm enough to hold it and prevent the testicle from slipping up towards the inguinal canal. The dressing is then completed by alternate circular and spiral turns of the bandage, and the two ends fastened together with a safety pin, and the whole surrounded with a suspensory bandage. This dressing may be reapplied daily.—*Univ. Med. Mag.*

#### INTUBATION FOR THE RELIEF OF STENOSIS OF TUBERCULAR LARYNGITIS.

Dr. F. E. Hopkins reports a case which was successful so far as the relief of the stenosis was concerned (*New York Medical Journal*, 1892, No. 691, p. 334). Massei has operated in three cases and Dillon Brown in one case, for the purpose of securing euthanasia. It seems likely that this operation, on account of ease and quickness, the comparative absence of shock, the absence of wound in tissues predisposed to necrosis, and the possibility that after a short time the tube may be dispensed with, ought always to be chosen instead of tracheotomy.—*Amer. Jour. Med. Sci.*

#### A CASE OF PORENCEPHALON.

Lloyd and Willard (*Amer. Jour. Med. Sci.*, April) report a case of porencephalon in which trephining was done for the relief of local symptoms, with death from scarlet fever. The patient was a boy, aged 7, with bilateral spastic hemiplegia, the right arm was the seat of athetoid movements, the legs, like the arms, were in a spastic condition, the knee-jerks were exaggerated, and ankle clonus was well marked on the left side. His general physical condition was good, but his mental condition was slightly impaired. His head was asymmetrical, but there were no scars or depressions. He came

under observation in October, 1891, and a month later had a series of convulsions, after which the athetoid movements of the right arm were more noticeable and his mental faculties were weakened. There was absolutely no history obtainable as regarded his early life. It was determined to trephine over the motor area on the left side. When the dura mater was incised a considerable amount of cerebro-spinal fluid escaped and the finger entered a vast cavity, so that evidently a large portion of the cerebrum was absent. Scarlet fever developed on the third day after the operation, and the child died from its effects on the nineteenth day. On *post-mortem* examination a large porencephalon was found involving the left Rolandic region, extending anteriorly beyond the prefrontal fissure downwards almost or quite to the operculum, backward to include the superior parietal lobule, its area thus coinciding very closely with the area of distribution of the middle cerebral artery. In the mid-region of the cavity was a large crater-like opening extending into the lateral ventricle. The authors express the opinion that vascular disease or injury must have been the origin of the cavity in the brain.—*Brit. Med. Jour.*

#### SPONTANEOUS CURE OF DETACHED RETINA.

Marchetti (*Rif. Med.*, January 16, 1892) reports the following case: A man, æt. 55, observed during November, 1890, that the vision of his left eye was becoming dim. This dimness increased very rapidly, and in four days there was left only perception of light. Examination revealed extensive detachment of the temporal and frontal portions of the retina, and of a great part of the nasal portion. The detachment fluctuated in the lower portion with the ocular movements; in the other parts it was distended in folds. Tension was reduced, vitreous transparent, and disc normal. Vision was restricted to P. L., and perception of movements of the fingers in the temporal section of the field of vision only. Vision had been previously good, but each cornea had a central leucoma, the remains of inflammation many years previously. He was treated with pilocarpine injections and iodide of potassium, and advised rest in the horizontal posture. In February, 1891, having continued the treatment till then,

the eye was in the same condition, when quite suddenly on the 16th, he regained his sight. This followed, apparently, on a sudden rotation of his head towards the right side, the patient feeling immediately, as it were, a blow on his useless eye. Directly after this he found that he could see objects distinctly and without any difficulty, and eight days after he could read small type quite easily. In June, when he again presented himself for ophthalmoscopic examination, there was a light grey streak corresponding to the detachment, but no displacement whatever remained. The field of vision was nearly normal, save for colors, and the acuity nearly as good as before, having regard to the existence of the old leucomatous areas. The author is inclined to attribute the sudden cure to a rupture of the detached portion, with escape of the subjacent fluid.—*Brit. Med. Jour.*

#### THE TREATMENT OF RECENT TRANSVERSE FRACTURES OF THE PATELLA.

Butcher (*British Medical Journal*, April 30, 1892) describes the following method of treating transverse fractures of the patella:

The fragments are at first adjusted by the hands of an assistant and then a stout, curved, pedicled needle, armed with a long, stout, silk ligature, is passed through the skin about the centre of the outside of the knee, then pushed slightly upward subcutaneously until it reaches the upper border of the patella; the needle is now thrust through the quadriceps tendon as near to the upper part of the bone as possible. The point of the needle is then depressed and the skin on the inner side of the joint drawn up and the point of needle then thrust through and withdrawn, leaving the silk ligature in place. The needle is again passed as before from the outer side of the joint through the same opening and directed slightly downward until the lower edge of the lower fragment is felt. The needle is then thrust through the ligamentum patella, the skin in the inner side of the joint being drawn down and the point forced through the same puncture that is already occupied by the silk ligature. The needle, having been passed unarmed, is now threaded with the end of the silk ligature and then withdrawn, with the result that the silk disappears

through the opening on the inner side of the knee and the two ends appear at the same opening on the outer side. The fragments are then rubbed well together so as to secure perfect apposition by the breaking up of clots, that may have intervened. The ends of the ligature are then drawn tightly together and knotted, with the result that the knot slips through the puncture. This ligature entirely surrounds the patella subcutaneously. There is no wound to dress and the joint is not interfered with. The joint is then dressed on a posterior splint and motion is not permitted for about ten days.—*Univ. Med. Mag.*

#### A NEW APPARATUS FOR THE TREATMENT OF SCOLIOSIS.

Schede (*Deutsche medicinische Wochenschrift*, No. 12) advises the apparatus here described in the treatment of scoliosis, and believes that more can be accomplished by this means than by measures formerly adopted.

The apparatus consists of a framework made of gas-pipe, consisting of four upright posts, joined together on three sides by cross-pieces. There are arranged two padded horizontal boards, which are movable, to hold the pelvis firmly. The anterior one is so padded that the symphysis remains free from pressure, so the development of the antero-posterior diameter of the pelvis is not unfavorably influenced. There is an upright bar from which is suspended the head-swing, held by a chain carried over two simple pulleys. A movable horizontal bar is also attached to this bar. By means of a screw it is put at such a height as will put the arms on the stretch when the head is in suspension. To the vertical rod is attached a ring made of gas-pipe of a size sufficient to go outside of the body of the patient. This ring is so arranged as to be readily raised or lowered. In this ring several upright rods are fastened which carry long horizontal screws with large pads on the end next to the body. Two of these pads act as shoulder-supports, which are provided with straps.

The others are used to make pressure and counter-pressure on the thorax with the view of correcting the deformity. To overcome the torsion, rubber adhesive plaster is placed on the back and sides of the patient; to this plaster is attached a cord which runs over a pulley on a level

with the attachment to the plaster, and pulling in a direction to overcome the deformity. Three to ten pounds are placed on the other end of the cord. The function of this is assisted by the pressure-pads, which, being on screws, are adjustable.

The head-swing is elevated until the patient rests on his toes. Half an hour is spent in the apparatus morning and evening.

Two cuts are inserted which greatly aid in elucidating this apparatus.

In bad cases a plaster of Paris bandage may be applied during the night, covering the pelvis and even part of the thighs.—*Amer. Jour. Med. Sci.*

#### OBSTETRICS.

##### TANGLING OF THE UMBILICAL CORDS IN TWINS.

Hermann (*Archiv für Gynäkologie*, Band XL., Heft. II.) describes the specimen from a case of knotting of the cords in twin pregnancy. The knot was between the first and second cords reckoned from the navel. Hermann believes that this condition, which occurs once in 5-6,000 pregnancies, is produced by long-continued violent movements of the body of the mother, as in dancing, riding, vomiting in the beginning of pregnancy, etc. The prognosis of tangling of the cords is extremely unfavorable for the children. In fifteen cases collected by him the pregnancy was interrupted eleven times and only one child was born living. In the other four cases, where the labor followed the regular end of pregnancy, five children were born living and three dead. The diagnosis of this condition during pregnancy is as impossible as its treatment.

—*Univ. Med. Mag.*

##### DEATH AFTER RETROFLEXION OF GRAVID UTERUS.

Treub (*Centralbl. f. Gynäk.*, No. 19, 1892) observed an almost moribund patient with incarcerated gravid uterus and symptoms of acute peritonitis. There had been no defecation for five days; vomiting had set in thirty-six hours before Treub saw her, and the bladder had been emptied twelve hours previously by the catheter. The uterus was replaced, but the patient died in two hours. At the *post mortem* the colon was found to be

compressed by the gravid uterus, and it was already gangrenous. Acute peritonitis had followed this complication. Treub has collected fifty fatal cases of retroflexion of the pregnant uterus, and in no case was death due to gangrene of the intestine. The recorded causes of death were: uremia, exhaustion, 13 cases; rupture of bladder, 11; septicæmia, 6; peritonitis after cystis, 10; pyæmia, 3; rupture of the peritoneum, 2; malpraxis, 5. Many cases, moreover, must have escaped observation or publication; nevertheless, it is not likely that sloughing of compressed intestine is otherwise than a very rare cause of death under the circumstances.—*Brit. Med. Jour.*

##### INHALATION OF OXYGEN IN OBSTETRICS.

Riviére (*Nouv. Arch. de Obstét. et de Gynéc.*, April 25th, 1892) has found, as the result of much experience, that inhalations of oxygen are valuable under many circumstances, both for mother and child. Thus inhalation is serviceable in counteracting the evil effects of chronic or acute thoracic diseases during pregnancy, which so often cause abortion or premature delivery. In uncontrollable vomiting and anorexia inhalations, are also useful. After delivery inhalations superoxidize the blood, which appears to enable that fluid to resist sepsis. When a pregnant woman is ill or weak, inhalations always profit the fetus, whose nutrition is thereby improved. Riviére goes so far as to contend that the method is of service in placental diseases, or even in partial detachment of the placentæ; it allows, he believes, more complete oxidation of the foetal blood in the diminished area of sound placentæ that remains. Altogether, however, he admits that inhalations are of more benefit for new-born children, whether they be emaciated from some cause which existed before birth, or continue to be thin for some period after delivery, owing to malnutrition.—*Brit. Med. Jour.*

#### GYNECOLOGY.

##### EUPHORIN IN GYNÆCOLOGICAL PRACTICE.

Bergerio (*Gazz. d. Osp.*, April 7, 1891) has tried the effect of topical applications of euphorin in 20 cases of ulcerative cre-

vicitis, in 4 of which the condition was complicated by eversion of the mucous lining of the cervix; after five or six applications the lesions were on the way to cure. He also used the drug in powder by insufflation and in a 1-in-3 alcoholic solution, and in this way cured some cases of septic endometritis. In order to avoid confusion, no other disinfecting agent was used at the same time, all washing out of the genital canal being performed with sterilized water.—*British Medical Journal*, suppl., April 30, 1892, p. 71.

#### THE TREATMENT OF UTERINE MOLE.

Fritsch in remarking upon the above case, describes his treatment in his own practice, and considers active interference strongly indicated. He employs the curvette as soon as possible, as the safest and most efficient means of checking the hemorrhage and terminating the case.

#### INTESTINAL OBSTRUCTION DUE TO DISPLACEMENT OF THE UTERUS.

Nélaton (*Nouvelles Archives d'Obstétrique et de Gynécologie*, 1892, No. 2) reports the case of a woman, aged twenty-eight years, previously in good health, who during a menstrual period was seized with colicky pains in the abdomen and vomiting, which persisted for three days, efforts to move the bowels being unsuccessful. Tympanities was excessive. On the fifth day gas escaped *per rectum*; on the eighth, the patient had a fluid movement, and no further observation was noted until the menses reappeared, when the symptoms of intestinal occlusion again developed. A rectal examination now revealed a cicatrical mass compressing the rectum at a point two and a half inches above the anus; the induration was continuous with the uterus, and was thought to be the remains of an old haemato-salpinx. It was situated so deeply within the pelvis that it seemed to be more accessible through a vaginal than through an abdominal incision. The cul-de-sac of Douglas was opened from below, and adhesions attaching the retroflexed uterus to the rectum were divided, when the former was readily replaced. Examination *per rectum* then showed that the obstruction had been re-

moved. The patient was discharged at the end of two weeks, and never had a return of the trouble.

Segond (*Ibid.*) reports the case of a patient, aged thirty-six years, who presented all the symptoms of acute intestinal occlusion. Under chloroform, a retroflexed uterus with a supposed fibroid at the fundus was replaced, by introducing the entire hand into the rectum, and the obstruction was overcome. Several months later vaginal hysterectomy was performed, and the tumor proved to be an ectopic gestation, which was removed successfully.—*Amer. Jour. Med. Sci.*

#### PEDIATRICS.

#### THE RADICAL CURE OF INGUINAL HERNIA IN CHILDREN.

Broca (*Revue Mensuelle des Maladies de l'Enfance*, April, 1892) describes the operative treatment of inguinal hernia in children, with report of seven cases.

This operation is of little importance in very young children.

- (1) The tissues are thin and delicate.
- (2) The parts are small and difficult to reach.

(3) A thorough anatomical knowledge is necessary.

Through fear of operations many surgeons have adopted other measures—especially the application of a bandage. This sometimes does result in the cure of these cases, but its application must be continued from two to three years. If the hernia be complicated by ectopia of the testicle, then operation must be resorted to. Operation in very young children—from one to three years—would only be justifiable where a gradually-increasing hernia should suddenly become irreducible or strangulated. Strangulation is a rare condition at these ages. Colotomy was formerly done in very young children for strangulation, with considerable success, but Broca believes the operation is rarely if ever necessary. Sometimes strangulated hernia can be reduced by pressure and carefully-applied tassis.

Two reasons are given by some authors why operations in earlier years should not be performed.

- (1) Operations in children up to five years are generally grave.

(2) Before five years the continued use of the bandage generally cures.

But if great care should be taken during the operation and in the after-treatment of the wound there is but little danger. A congenital hernia, without being a pro-peritoneal hernia, may have a dilatation, retro-peritoneal or pro-peritoneal. These conditions were found in four adults operated upon. He thinks that pressure will cause obliteration of the inguinal canal; but how can that possibly effect this pro-peritoneal pocket.

Of the seven cases reported, the ages varied from five months to twelve years. One case at five months was cured by means of a bandage. The remaining six cases were all operated upon, and only one was complicated by ectropion of the testicle. All the cases resulted in cures in from four to eight weeks.—*Univ. Med. Mag.*

#### EXTIRPATION OF LARYNGEAL PAPILLOMA IN CHILDREN THROUGH A FENESTRATED TUBE.

Lichtwitz (*Arch. Clin. de Bordeaux*, No. 4, 1892) has successfully treated papilloma of the larynx and the upper part of the trachea by introducing a fenestrated tube. The position of the growth is first determined with the laryngoscope, and a tube of the pattern of O'Dwyer's tubes, but having a fenestra at a point corresponding to the point at which the growth is attached, is introduced in the ordinary way. The papilloma ought then to project into the tube. The operator introduces, with a finger as guide, a forceps or a *porte-caustique*, and removes or cauterizes the growth. The tube should be cylindrical and should have thin walls, and should be blackened on the inner surface. Examinations made on the dead body showed that the upper border of the tube always rested on the ventricular bands, and that the neck of the tube corresponded to the vocal cords. By noting this it was possible to cut the hole in the tube at a point corresponding very accurately to the site of the papilloma. As these growths are generally situated anteriorly, it is best, if the tumor cannot well be seen with the laryngoscope, to introduce a tube with an anterior fenestra, in the hope that the growth may project through it. If this fails, still more information is almost sure

to be obtained. One case is related (a girl aged 4½ years) in which a mass of papilloma in the anterior commissure was removed piece-meal at six sittings, and the base cauterized.—*Brit. Med. Jour.*

#### HYGIENE.

#### THE BACTERIA OF MELONS.

Dr. Byron Halstead in the *Botanical Gazette*, November 11, 1891, describes a disease of melons and cucumbers on specimens from Bangor, Maine, and the central parts of New Jersey. To prove that the diseased plants were suffering from the results of the life of micro-organisms, numerous inoculations were made with the bacteria found in the diseased parts. The result was conclusive. The inoculated parts soon rotted and became affected in the same manner in which the original disease presented itself. Experiments were conducted also with seeds. Two lots, consisting of sixteen seeds, had been planted in two different pots, both of which were placed in the same conditions and surroundings. One of the pots was watered with water containing these bacteria, and only two germinations resulted, both of which died shortly, while in the other pot watered with pure water, the germinations produced good plants.—*Annals Hygiene.*

#### THE BEHAVIOR OF ANTISEPTICS TOWARD SALIVARY DIGESTION.

Under the above title Prof. Weber, of Columbus, Ohio, publishes in the *Journal of American Chemical Society*, January, 1892, the result of tests made under his direction by C. T. Fox. The agents used in the experiments were borax, salicylic acid, calcium sulphate and saccharine. The tests were made with one grain of starch in 15 c. c. of water, and 5 c. c. of saliva, with various amounts of antiseptic, and with varying times, ranging from 1 to 60 minutes. The effect was determined by estimating the sugar formed with the starch alone, and with the antiseptic added.

It was found that when the antiseptics were present in the proportion of 1 to 210 parts of the mixture, the diastatic action of the saliva was entirely arrested by all these agents during the first five minutes.

For the longer times, calcium sulphite was without effect, while borax retarded the action, and salicylic acid and saccharine completely arrested it. These last two agents prevented the action of saliva upon starch when present in the proportion of 1 in 420. Salicylic acid greatly retards the action when present in the proportion of 1 in 840; but not when the proportion was reduced to 1 in 1050. Saccharine showed no effect when the proportion was reduced to 1 in 840. Calcium sulphite failed to retard the action when present in the proportion of 1 in 420. Borax showed a great retarding effect, even in the proportion of 1 in 2100. These experiments were undertaken to determine the effect of the various preservatives for food containing them, and showed that mixtures containing them should not be permitted to be added to articles of food.

#### MEDICAL CHEMISTRY.

##### A TEST FOR THE PURITY OF TEREBENE.

A dispensing query which appeared in a recent issue of the *Chemist and Druggist* has suggested to Harold Wyatt, Jr., the following test as a ready means of detecting the freshness of a given sample of terebene:

R	Iodide of potassium.....	30 grains.
	Compound powder of tragacanth (B.P.).....	.60 grains.
	Boiling water to.....	8 ounces.—M.
	Allow to cool before using.	

Fifteen minimis of the suspected liquid are added to 1 ounce of this test solution contained in a glass-stoppered bottle, and the whole set aside with occasional agitation for one hour, at the end of which time if a blue color makes its appearance the sample is considered bad.

The results vary somewhat with different terebene and turpentines, as the following table shows:

	1 hour.	12 hours.	24 hours.
A. Terebene.....	No color.	No color.	Pink blue.
B. Terebene.....	Faint pink.	Blue.	Dark blue.
C. Oil terebinth rect.	Blue.	Blue black.	Blue black.
D. Oil terebinth, comm.	Purple.	Blue black.	Blue black.

Sample A was from a well-known firm, and had been sent out in 1 ounce capsules bottles, so that the chances of oxidation were greatly diminished. Sample B was from the dispensing counter, and was contained in a 1-pound bottle three-fourths full.

Mr. Wyatt adds that if oil of lemon be old it will react in the same way as terebene, but fresh oil has no reaction. This might be useful as a guide to the quality of oil of lemon, one more trustworthy, perhaps, than the sense of smell alone.

The color produced in this test is, of course, formed by the reducing action of the H<sub>2</sub>O, contained in all old samples of turpentine and terebene, on the iodide of potassium and the subsequent formation of iodide.

#### IODIDE OF CYANOGEN.

This poisonous compound, which is soluble in water or alcohol, has been recommended by Prof. Kober as an efficient destroyer of all lower animals. A recent report of E. Merck recalls this fact, and suggests its use for the preservation of zoological specimens in general, etc.

It is to be stated that general caution must be exercised with this substance, since it is notably volatile even at the ordinary temperature. For this reason, also, its use as a permanent preservative of the objects before mentioned is rather problematical.

#### NEWS AND MISCELLANY.

##### "CHICAGO MEDICAL RECORD."

*Chicago Medical Record*, edited by Dr. Archibald Church, and previously published by W. T. Keener, of Chicago, is now being published by that well-known house, the M. H. Kauffman Medical Publishing Co.

##### CRAWFORD COUNTY, PA., MEDICAL SOCIETY.

At a meeting of the Crawford County, Medical Society, held July 5, 1892, the following actions were taken:

WHEREAS, The practice of criminal abortion is steadily increasing, and, in the numerous cases which prove fatal, it is next to impossible to secure the conviction of the guilty party, because the testimony of the female—who is usually the only available witness in the transaction—is not received by the courts, whereby the evil-doer not only escapes punishment, but is encouraged in his work, therefore be it

*Resolved*, That we petition the Legisla-

ture of this State, at the coming session, to enact a law by which the dying declarations of a person, who may die from the effects of a criminal abortion, shall be received as evidence on the trial of any one indicted for the same as is now done in cases of homicide.

*Resolved*, That a copy of this resolution be sent to the various county medical societies of the State for concurrent action, and a copy also to each of the medical journals published within the State.

J. M. COOPER, M. D.,  
*Secretary.*

#### A SLUR ON THE MEDICAL PROFESSION OF CHICAGO.

The *British Medical Journal* says: "Slow going Europe was much amused at the characteristic official methods employed at Chicago to meet the unpleasant effect produced by the publication of the figures representing the epidemic and endemic prevalence of typhoid fever in that city, and the extensive pollution of the lake water with which the city is served. There were 2,000 deaths reported from typhoid fever in 1891, and 311 deaths from typhoid in January of the present year. There was also evidence that the sewage of a city of some one hundred and eighty thousand persons passes directly into the lake, and that further pollution is brought about by means of the Chicago River, which communicates with the Mississippi as well as Lake Michigan. The simple reply made to this was that the doctors did not know how to diagnose typhoid fever, and that probably not more than four hundred out of four thousand cases so reported were correctly entered. We have been waiting with amused wonder for the response of the maligned medical faculty to this serio-comic retort, which would only be regarded as a bad and foolish joke in any other civilized city, whether of Europe or America. Meantime, it is instructive to note that instead of giving solidity or confirmation to the promise held out by Mr. MacCormack, the Commissioner in Great Britain, that the sources of water supply would be, in good time before the Exhibition, carried two miles further out into the lake, the *mot d'ordre* appears to be to give this significant hint

to the doctors that for the future they had better register what they have been in the habit of recognizing as typhoid fever under some other name. This will not, however, diminish the mortality, nor will it add to the confidence with which future and, perhaps, more reassuring returns will be regarded by intending visitors to the Columbian Exposition."

#### INCREASED DRUNKENNESS IN WOMEN.

It is a matter of common belief that drunkenness in women is increasing very much. This view has received confirmation at an inquest a few days ago touching the death of Mary Zeig, aged sixty-seven, an habitual drunkard. Dr. Norman Kerr testified that death was due to apoplexy consequent on habits of intemperance. She had been drinking three weeks continually, and on Friday had gone to a public-house and taken a quantity of rum. Dr. Kerr said he had never seen such a number of drunken women as in the Whitsuntide holidays. He had frequently seen groups of four or five—some quite young—in a state more or less intoxicated. He could only attribute it to the hot weather. We are afraid the cause lies deeper than in the weather. Dr. Danford Thomas stated that he had held lately an increased number of inquests upon women, many comparatively young, whose death was clearly due to alcoholic excess. This kind of evidence is very serious, and emphasizes an evil which is about to be inquired into by a Department Committee. The jury were affected by the representations of the coroner and Dr. Kerr, and urged on the Committee the urgent necessity of compulsion in the treatment of chronic inebriates. The existing law is entirely inadequate. It is of use only to the wealthy, who can afford to go to retreats, and to those who have self-respect enough left to go voluntarily. Dr. Kerr suggested the creation of a special prison for the compulsory treatment of such cases. It might be called by some other name. But the suggestion is in the right direction and should be seriously considered by the committee. The condition of our chronic inebriates, and of the laws relating to them, are disgraceful to us, and deserve the anxious attention of statesmen of all parties.—*Lancet.*